



# Southwest Michigan Dermatology

## Authorization of Treatment of a Minor

In my absence I hereby authorize the providers and staff of Paragon Health, PC DBA Southwest Michigan Dermatology to administer treatment or medication and perform any procedures as may be deemed medically necessary for the diagnosis and treatment of \_\_\_\_\_ DOB \_\_\_\_\_, a minor 16 years or older.

Minor may be treated without parent or adult present.

\_\_\_\_\_  
Authorizing Person (Parent or Guardian)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

### Authorized Person(s) other than Parent or Legal guardian

I hereby authorize \_\_\_\_\_ to authorize treatment, medication, or procedures as may be deemed medically necessary for the diagnosis and treatment of \_\_\_\_\_, a minor.

Above named adult(s) must be present for the minor to be treated.

\_\_\_\_\_  
Authorizing Person (Parent or Guardian)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

I do not authorize anyone, other than Parents or a legal guardian, to authorize treatment, medication, or procedures as may be deemed medically necessary for the diagnosis and treatment of \_\_\_\_\_, a minor.

\_\_\_\_\_  
Authorizing Person (Parent or Guardian)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date