MD | MITTAL DERMATOLOGY

MINOR PATIENT AUTHORIZATION FOR TREATMENT WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT

Patient Name: _____

Date of Birth: _____

I, _____, am the parent/legal guardian of the above-named minor and authorize Mittal Dermatology and its providers to evaluate and treat my child during scheduled office and/or telehealth appointments without my physical presence.

I understand that this authorization permits routine dermatologic evaluation, discussion of treatment options, prescription of medications when medically appropriate, and follow-up care. I acknowledge that the provider may contact me if additional consent or discussion is necessary and may require my presence if deemed medically appropriate.

I understand that I remain responsible for all medical decisions made on behalf of my child and for any financial obligations related to their care.

This authorization will remain in effect until revoked by me in writing or until the minor reaches the age of majority, unless an earlier expiration date is indicated below.

Expiration Date (Optional): _____

Parent/Legal Guardian Name: _____

Signature: _____

Date: _____

Phone Number: _____