Clayton Dermatology Group
2010 Thonotosassa Road
Plant City, FL 33563
(813)752-0757

Authorization for Minor Child to Be Accompanied by Person Other than Parent for Dermatology Appointment

Date: ____________________

Patient Name: ___________________________________

Patient DOB: ___________________________________

Authorizing Parent Name: ___________________________

I _________________________________ (parent name) authorize that my child

__________________________________ (patient name) may be accompanied by

__________________________________ (name authorized to accompany patient) to

dermatology appointments with Clayton Dermatology Group. My child may be examined and information regarding patient care may be discussed with the authorized person above. No treatment is authorized without my written consent, but patient may be examined, treatment discussed, and prescriptions written as needed. I understand that I may contact Clayton Dermatology Group if I have any additional questions regarding patient's diagnosis, treatment options, prescriptions discussed during the appointment.

I authorize patient be accompanied by person above for (Circle)

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Specific Visit Dates (List): _________________________________

Ongoing Care