Clayton Dermatology Group

2010 Thonotosassa Rd.

Plant City, FL 33563

(813) 752-0757

Authorization for Minor Child to be Accompanied by Person Other than Legal Guardian for Dermatology Appointment

Date: ______________________________

Patient Name: ____

Patient DOB: ____

Authorizing Legal Guardian Name: _______________________________________

I ______________________________________(legal guardian 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. Patient may be examined, treated 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 visits and authorize the above person to consent for procedures.

Parent/legal guardian signature: _______________________________________ Date: ______________