CONSENT FOR MINOR TO BE SEEN WITHOUT PARENT/GUARDIAN

2148 N Damen Avenue
Chicago, IL 60647
Phone 773-938-8128
Fax 773-938-8126

I give permission for ________________________________,
Name of child/minor

to be seen by the doctor without a parent or guardian present. I authorize the doctor and Dermatology Physicians Group personnel to deliver routine medical treatment to my child. Routine medical care includes, but is not limited to, medical evaluation, physical exam, injections, lab work, prescription medications, and procedures (procedure examples: liquid nitrogen, biopsies, cantharidin application, suture removal, etc.). I agree to be available by phone and to be financially responsible for all copays, coinsurance, and any other charges not covered by insurance.

_____ - Permission is valid for visits from ______________ to ______________.
Starting Date End Date

_____ - Permission is valid for all future visits unless revoked by written communication.

______________________________ ________________
Patient Name (print) Patient Date of Birth

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Parent/Guardian Name(print)

______________________________ ________________
Parent/Guardian (signature) Date