mid-atlantic skin surgery institute

Verghese & Ling, MD PA

MEDICAL SKIN CARE COSMETIC PROCEDURES SKIN CANCER TREATMENTS

MINOR AUTHORIZATION

For families who are ongoing patients of the Practice, it may be more convenient to have prior authorization for medical care delivered to minors without a parent or guardian having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize Mid-Atlantic Skin and its personnel to deliver medical care to my (our) child listed below:

Name: _____ Date of birth: _____

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

Parent's name: _____

Phone (office/home): _____

Parent's name: _____

Phone (office/home/cell): _____

Other (relationship): _____

Phone (office/home/cell): _____

Signature: _____

Date: _____

Print name and relationship: _____

NOTE: *If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.*

_____

_____

Signature: _____

Printed name: _____

Phone: _____

St. Patrick's Centre 173 St. Patrick's Drive Suite 201 I Waldorf, MD 20603 I 301-396-3401
Shanti Medical Center 26840 Point Lookout Road I Leonardtown, MD 20650 I 301-475-8091
Wildewood 23415 Three Notch Road Suite 2052 I California, MD 20619 I 240-237-8268

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