

MINOR AUTHORIZATION FORM

***The following information must be completed in its entirety for any minor patient under the age of 18 to be seen without parent/guarantor/legal guardian present at the date and time of service: (the person bringing the patient to the appointment must be 18 years old or older and be able to show identification)***

***THE PERSON FILLING OUT THIS FORM MUST BE ON THE PATIENT’S ORIGINAL PAPERWORK FILLED OUT AS A NEW PATIENT***

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How can we contact you at appointment time if necessary? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am authorizing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to bring my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to their appointment on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. What is this persons’ relationship to the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I am authorizing Mid-Atlantic Skin Surgery Institute and its personnel to deliver medical care to my child. I acknowledge that a minor authorization form must be filled out for each date of service in which I am not present. I am providing a contact number for the date and time of service in case I need to be reached. This form can be obtained by going to our Mid-Atlantic Skin Surgery Institute website under the forms tab.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*OFFICE PERSONNEL MUST SCAN THIS FORM IN PATIENT’S CHART AT THE TIME OF SERVICE\*\****

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