South Shore
skin center

AUTHORIZATION TO TREAT A MINOR

One Scobee Circle, Plymouth, MA 02360 P 508.747.0711
75 Washington Street, Norwell, MA 02061 P 781.878.6495

SouthShoreSkinCenter.com

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____

Home Address: _____

City: _____

State: _____

Date of Appointment: _____

PARENT/GUARDIAN COMPLETE THE FOLLOWING:

I, the undersigned parent/legal guardian, of the minor named above, do authorize the physicians and/or physicians assistants of South Shore Skin Center to provide healthcare services to this minor in the absence of a parent or legal guardian. I understand that the healthcare services may include, but are not limited to: examination, medical or surgical diagnosis, local anesthetic, and preventive and /or curative treatment.

State any restrictions or exceptions: _____

_____

_____

Parent/Guardian Name (please print or type): _____

Parent/Guardian Signature: _____

Date: _____

Telephone number where you can be reached at the time of the minor's appointment: _____

Home Phone: _____

Cell: _____

Work: _____

Please fax completed form to: 508-746-9265 (Plymouth office) or 781-878-6524 (Norwell office) or mail to one of the above office addresses, or have your child bring it with him/her to the appointment.