AFFILIATED TROY DERMATOLOGISTS

Marcia Cardelli, MD,
Traci Kimbrough, MD
Snehal Desai, MD

Authorization for Treatment of An Unaccompanied Minor

Date:_____

I authorize Affiliated Troy Dermatologists to give follow up treatment for _____, to the minor (Patient Name) _____, (Date of birth)_____ at all unaccompanied visits. Affiliated Troy Dermatologists will be able to get in contact with me by phone at anytime during the visit at the following number _____. If I cannot be contacted, I understand the minor may be sent home without being seen.

I have read and understand the above and agree with these provisions.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Witness Date