Bluegrass Dermatology
Skin Surgery Center, P.S.C.

Authorization for Treatment of a Child

Name of Child: _____ Child's Birth Date: _____

Name of Consenting Parent/Legal Guardian: _____

Parent or legal guardian consent must be provided for treatment of a child (minor patient under the age of 18). We understand there are times that it may not be possible for you to accompany your child to each visit and it may be more convenient to have prior authorization for delivery of medical treatment directly to a child without the parent or legal guardian being present. Therefore, the providers in this office will accept the below authorization to treat your child for any visit. If you wish to authorize treatment to your child when another adult brings your child in, this authorization must specify the name(s) of the adult(s) over the age of 18 who is authorized to bring your child in for treatment.

☐ By checking this box, I DO authorize treatment of my child when my child is not accompanied to the office by me or any of the adult(s) listed below. The providers may give any such treatment the providers determine is appropriate for my child, including but not limited to preventive care visit, physical exam, re-check, sick visit, diagnostic examination, immunizations and injections, biopsies or surgical procedures, lab tests, and prescription of any medication deemed necessary at that time.

☐ By checking this box, I DO NOT authorize treatment of my child unless accompanied to the office by me or any of the adult(s) listed below.

(Complete this section only if you want another adult to be able to bring your child in for treatment)

I give the office authorization to treat my child for any such treatment the providers determine is appropriate for my child, including but not limited to preventive care visit, physical exam, re-check, sick visit, diagnostic examination, immunizations and injections, X-rays, lab tests, and any prescription of any medication deemed necessary when brought to the office by the following adult(s):

_____ _____
(Print Name of adult) (Print Relationship to child)

_____ _____
(Print Name of adult) (Print Relationship to child)

_____ _____
(Print Name of adult) (Print Relationship to child)

Since the adult(s) named above are involved in my child's health care, I further authorize that the providers can give and discuss with the adult(s) protected health information (PHI) about my child and understand that the adult(s) listed above will be responsible for conveying any such PHI given by or discussed with the providers to me. I further authorize the release of PHI to the adult(s) named above concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions if any such information is contained in my child's medical record.

REVOCATION OF AUTHORIZATION

I agree that if at any time, I no longer want the providers to communicate with the adult(s) named above, or no longer want this authorization to be effective, I will immediately notify the office in writing by sending a letter to my Group Health office, Attention: Medical Records. The revocation will be effective 5 business days after receipt to allow time for processing. The revocation will be deemed a revocation of this authorization in its entirety. I understand that if I want to allow for any future authorization for treatment of my child, I will have to complete and sign a new authorization.

This authorization is in effect for a period of one year from the date signed below unless revoked sooner.

_____ _____
(Signature of Parent/legal guardian) (Date)