For Patients Under 18 Years of Age

PARENT OR LEGAL GUARDIAN OF :

First: Last:

Address:

City: State: Zip:

Home Phone: Day Phone:

Date of Birth: Social Security Number:

Email: Employer:

Relationship To Patient (circle one):

(a) Parent (b) Legal Guardian (c) Other:

AUTHORIZATION TO TREAT MINOR. As either the natural parent or legal guardian of the above named patient, I authorize The Skin Group, PLLC physicians or mid-level providers to evaluate and administer medical care to my minor chld. In the case of my child aged 18 or older, consent to evaluate and administer medical care is granted in accordance with my child's personal request and need and physician's or mid-level provider's professional judgment.

Signed: Date:

(Parent or Legal Guardian)

Spring River Business Park, 2307 River Rd, Ste 101• Louisville, KY
Hester Medical Plaza, 1868 W. Hebron Lane, Ste 200 • Shepherdsville, KY 40165

p: 502-583-6647 •**f:** 502-585-4824