Alaska Center for Dermatology, P. C.
3841 Piper Street | Suite T4-020 | Anchorage, AK 99508 | telephone 907.646.8500 | fax 907.646.9760

Authorization for Sixteen (16) and Older Minor Alone

Patient Name _____**DOB**_____

I, *(printed name)* _____, make an oath that I am the lawful guardian of the child listed above, and I authorize for them to be examined and treated by the Alaska Center for Dermatology in my absence.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my child's condition and that I am responsible for all charges incurred. This authorization will remain in effect for one year from the date signed unless canceled sooner in writing.

I can be reached at *(phone number)* _____ with any questions.

_____
Parent/Legal Guardian Printed Name

_____ _____
Parent/ Legal Guardian Signature **Date**

_____
Expiration Date ***(one year from signature date)***

Updated 10/26/18