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 Minor with Agent

Patient Name ____**DOB**________________

I, *(printed name)* ____, make an oath that I am the lawful guardian of the child listed above and that there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

I hereby appoint the below person(s) as my agent. My agent may consent to the examination and treatment of the child listed above. 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.

Agent Name ____

Phone Number ____

Relationship to Patient ____

____
Parent/Legal Guardian Printed Name

____ ________________
Parent/ Legal Guardian Signature **Date**

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

Updated 9/20/18