| Authorization for Treatment to Minor | |
|---|---|
| Minor's Name in Full | |
| Date of Birth | Medical Record Number |

I/We the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physicians of Idaho Skin Surgery Center, PC. to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgement as to the requirements of such diagnosis or medical treatment in my/our absence.

NOTE: Not used as permission for vaccines.

This consent shall remain in effect until revoked in writing, by parent(s) or legal guardian(s), or until child may legally consent for him or herself.

| Signature-Parent or Legal Guardian | Date |
|---|---|
| Person(s) Authorized to Attend Appointment(s) with Minor | Date |
| Witness | Date |

**I declare under penalty of perjury under the laws of the state of Idaho that the forgoing is true and correct.**

| Signature | Date |
|---|---|

County of ______________________)

State of _______________________)

Subscribed and sworn to before me on this _______day of _______________________, 20 _____.

Notary Public

**NOTARY STAMP**

_____________________________________________

Commission No.

_____________________________________________

Commission Expires

_____________________________________________