WILMINGTON
DERMATOLOGY
CENTER

**Consent to Treat a Minor without a Parent/Guardian Present**

In an effort to meet the rules and standards set forth by HIPAA and the NC Medical Board we require a signed consent from the parents or legal guardian of any minor (anyone < 18 yrs old) who may receive treatments for a diagnosis that is non-life threatening. This consent form is your way of authorizing WDC and it's medical providers to evaluate your child in the case you cannot accompany them to their visit. Additionally it provides you the option to give us permission to perform specific reoccurring medical treatments that might be an outcome of a diagnosis made in our office (ex. reoccurring wart freezing, etc)

This record will scanned and maintained along with your child's medical records on file and will be the basis for any action taken.

Patient Name _____ Patient DOB: _____

**I _____ (parent or guardian) grant WDC the ability to perform the following in my absence. Initial and date all that apply.**

| **Action** | **Initial** | **Effective Date Range From** | **To** |
|---|---|---|---|
| Conduct a Routine Exam | _____ | _____ to | _____ |
| Conduct the following procedures | | | |
| _____ | _____ | _____ to | _____ |
| _____ | _____ | _____ to | _____ |
| _____ | _____ | _____ to | _____ |
| _____ | _____ | _____ to | _____ |

*Optional:* Additional Authorized User (outside of a parent or guardian on file) who may make medical decisions in my absence (if applicable) Name: _____ DOB: _____

I have read and understood the above information. My questions have been answered by the treating physician and staff to my complete satisfaction.

| _____ | _____ | _____ |
|---|---|---|
| Patient's Parent/Guardian (Please print) | Signature | Date |