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Marietta, GA 30068-4382

Midtown
1109 West Peachtree Street NW
Atlanta, GA 30309-3608

Consent to Treat a Minor/Vulnerable Adult

Patient Name:_____

Patient DOB: _____ Patient Acct #: _____

I am the parent/guardian/legal representative of the above named patient and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the physicians and their staff at Dermatology Affiliates to treat the above named patient as outlined below: (Check all that apply)

- ☐ For all future visits
- ☐ For all conditions
- ☐ When alone
- ☐ On the following date(s): _____
- ☐ When accompanied by _____
  (name/relationship of person to accompany patient)
- ☐ For the following condition(s): _____

_____ _____
Signature of Parent/Guardian/Legal Representative Date