rev 01/11/12

**Acct #** _____

**Micki Ly, MD**

*Aloha Dermatolgy & Laser Center*

# AUTHORIZATION FOR TREATMENT OF MINOR

| **LAST NAME** | **FIRST NAME** |
|---|---|
| **BIRTH DATE**<br>___ ___ / ___ ___ / ___ ___ ___ ___ | **GENDER**<br>[ ] Male<br>[ ] Female |

| **MOTHER'S NAME** | Street Address | City | State | Zip Code |
|---|---|---|---|---|
| Mother's Phone | Mother's Occupation / Employer | Work phone | Does the client live with you?<br>[ ] Yes [ ] No | |

| **FATHER'S NAME** | Street Address | City | State | Zip Code |
|---|---|---|---|---|
| Father's Phone | Father's Occupation / Employer | Work phone | Does the client live with you?<br>[ ] Yes [ ] No | |

**Please select all that apply:**

[ ] I authorize my child to be unaccompanied during their appointments.

[ ] I authorize the listed personnel mentioned below to accompany my child to their appointment and authorize any treatments that needs to be performed by Micki Ly, MD and other trained professional under the doctor supervision. This includes examination, treatments, x-ray examination, laboratory tests, local anesthetics, and medical diagnosis.

| **NAME** | **RELATIONSHIP TO PATIENT** | **PHONE NUMBER** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

I understand that this authorization is given in advance of any specific diagnosis, treatment, of hospitalization in order to avoid delay in providing such treatment as is deemed necessary by the doctor(s).

I understand that I am responsible for any financial responsibilities including copays, coinsurances, and deductibles.

This authorization to treat will remain in effect until minor is 18 years old or unless revoked sooner in writing.

**PARENT/GUARDIAN SIGNATURE** _____ **RELATIONSHIP** _____

**(over 18 only)*

**PRINT NAME** _____ **DATE** _____