Craig Singer MD Dermatology PLLC

Parental Pre-Authorization for Medical Care to Children

For families who are ongoing patients of **Craig Singer MD Dermatology**, it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent and/or legal guardian having to be present prior and/ or during the treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatments in advance.

Authorization

I request and authorize Craig Singer MD Dermatology and its personnel to examine and treat my child for his or her skin condition in my absence. Types of treatment include, but are not limited to: injection of acne cysts, freezing or other destructive treatments of molluscum and warts, skin biopsy, incision and drainage of an absess, and blood draw.

This Authorization will remain in effect until otherwise indicated.

Child's Name: _____
Child's Date of Birth: ____ / _____ / _____

Please List below any specific instructions regarding the care of your child:

_____
_____

_____
_____

Signature of Parent/ Legal Guardian: _____
Date: _____ / _____ / _____

Note: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain below and provide appropriate documentation to be kept on file.