Advanced Dermatology Care (ADC) requires consent by a Parent, Legal Guardian, or Medical Power of Attorney in order to provide treatment for a patient who has a disability or a minor that cannot give consent to receive medical treatment for themselves.

In the event where this patient is accompanied to ADC by someone other than the Parent, Legal Guardian, or Medical Power of Attorney; the below authorization must be presented to the clinic prior to providing treatment. Please note that a Parent, Legal Guardian, or Medical Power of Attorney **must** be at the initial visit.

If ADC does not have written consent "to treat" on file at time of visit, the patient will not be seen.

I, _____________________________ (Parent, Legal Guardian, or Medical Power of Attorney) give consent for the individual(s) identified below to bring ___________________(Patient) with DOB ____/_____/____ to ADC for medical treatment. I hereby authorize ADC to provide medical care in accordance with the authorization and without obtaining additional consent from me.

Print name of person(s) able to bring patient in for appointment:

Name:	*Relationship:*
Name:	*Relationship:*

Parent, Legal Guardian, or Medical Power of Attorney information:

*Print Name:*_____________________________

Signature: ______________________________

Relationship to patient: ___________________

Phone Number: (____)_______-___________

Date of signature: _____/______/_____

(THIS FORM CAN BE REVOKED AT ANY TIME)