

*Charlotte Dermatology, P.A.*

**Charlotte Office**

2630 East Seventh Street • Suite 200  
Charlotte, North Carolina 28204  
Phone 704-364-6110 • FAX 704-364-4245

**Matthews Office**

101 East Matthews Street • Suite 800  
Matthews, North Carolina 28105  
Phone 704-847-7969 • FAX 704-849-2257

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Responsible Party's Name: \_\_\_\_\_

Emergency Name \_\_\_\_\_

Emergency Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell \_\_\_\_\_

**Consent to Treat a Minor**

The undersigned hereby requests and authorizes Charlotte Dermatology, PA to perform diagnostic test and treatment to \_\_\_\_\_ a minor child.

Patients Name

This authorization extends to all other clinics, doctors, office staff members, and intended to include radiographic examination at the doctor discretion.

As of the date below, the undersigned states and avows to have the legal right to select and authorize health care services for the minor child named above.

If applicable, under the terms and conditions of divorce, separation or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize the care should be revoked or modified in any way, the undersigned does hereby agree to notify Charlotte Dermatology, PA as soon as possible.

\_\_\_\_\_  
Signature of person authorized to sign for patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness