San Luis Dermatology & Laser Clinic, Inc.

15 Santa Rosa Street – San Luis Obispo, CA 93405 ~ Phone: (805) 541-2650 Fax: (805) 541-4043

AUTHORIZATION FOR TREATMENT OF A MINOR

IN THE ABSENCE OF THE PARENT

Date:_______________________

Minor's Name:____DOB:_________________

I____

(**Print** Minor's Parent Name)

am aware that my child may require treatment when I am not able to be present. In my absence, I

give ____DOB:______________________

(**Print** Individual name)

____, _______________________________

(**Print** relationship to the patient) (Driver's License or other **ID** number)

my permission to schedule, transport to and authorize medical treatment for my child.

I hereby give permission to ☐R. Jeffrey Herten, M.D. ☐Michael P. Heffernan, M.D. ☐ Craig Wiggins, NP-C

to examine and provide treatment to my child.

___________________________	___________________________	________________
Print Parent/Legal Representative Signature	**Signature** Parent/Legal Representative	Relationship to Patient
___________________________	___________________________	________________
Print Authorized Parent Representative Name	**Signature** Authorized Parent Representative	Relationship to Patient
___________________________	______________________	
Witness to Signature	Date/Time	

This agreement begins______________________and ends________________________