

**Hill Center for Dermatology, PC**

17560 S. Golden Road, Suite 100

Golden, Colorado 80401

303-526-1117

Fax 303-278-0611

**Consent for treatment of minors**

When appropriate, it may be more convenient to have medical care delivered to minors without having a parent present. If you wish to authorize such treatment please review, complete and sign the following consent.

**AUTHORIZATION**

I request and authorize *Hill Center for Dermatology, PC* and its personnel to deliver medical care in my child(ren) listed below:

**PLEASE PRINT**

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

DOB: \_\_\_\_\_

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

DOB: \_\_\_\_\_

Print Parent's name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (home): \_\_\_\_\_

Phone (work) : \_\_\_\_\_

Phone (cell): \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date