VERUM CUTIS DERMATOLOGY

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Consent for Minor to Be Seen Alone

Date: _____

Patient Name: _____

Patient DOB: _____

Parent/Guardian Name: _____

I, the undersigned parent or legal guardian, authorize my minor child to attend routine appointments at Verum Cutis Dermatology without a parent or legal guardian present.

This authorization includes routine follow-up visits, evaluation of new concerns, and noninvasive medical care as determined appropriate by the treating provider.

Procedures requiring separate consent will not be performed without obtaining the necessary parent or legal guardian authorization. This form does not replace consent required for specific treatments or procedures.

This permission is for the following time period (check one):

- ◯ Today only
- ◯ One year from the date signed
- ◯ Until the patient turns 18

I understand that I may revoke this authorization at any time by notifying Verum Cutis Dermatology in writing.

Parent/Guardian Phone Number: _____

Parent/Guardian Signature: _____

Date Signed: _____