Kallgren Dermatology Clinic
3434 47th St. Suite 200 Boulder, CO 80301
Phone 303-444-8100 Email kallgrenderm@comcast.net

Parental Consent for Medical Care to Children

This form is for families that are current patients of Kallgren Dermatology Clinic. For your convenience please complete and sign this form. This signed form may be delivered by a minor without the requirement that a parent or guardian be present at the time of service. Please review the following authorization for treatment and provide the information required below to authorize treatment in advance.

Authorization:

I/we authorize Kallgren Dermatology Clinic and its personnel to provide medical care to my/our child(ren) listed below:

Child's Name: _____ DOB: _____ mm / dd / yy

Child's Name: _____ DOB: _____ mm / dd / yy

Child's Name: _____ DOB: _____ mm / dd / yy

Child's Name: _____ DOB: _____ mm / dd / yy

Please contact me/us regarding the medical care provided to my/our child(ren) at the phone number(s) listed below:

Parent/Guardian name: _____ Phone # _____

Parent/Guardian name: _____ Phone # _____

Other: _____ Relationship: _____ Phone # _____

If there are any special parental or custodial relationships, please explain in the space below with your name, signature, and phone number where you can be contacted.

_____

_____

_____

Copays are due at the time of service. Please ensure your child(ren) has/have a means in which to satisfy this requirement to authorize Kallgren Dermatology Clinic to charge your Visa, Master Card, Discover or American Express for the copay.

Credit Card Number_____

Expiration Date_____ Security Code_____

Signature_____