

# *Alaska Center for Dermatology, P. C.*

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## Authorization for Minor Appointment

Date: \_\_\_\_\_

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

Patient Date of Birth: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

**I authorize for the above-named patient to be seen and treated by the Alaska Center for Dermatology in my absence.**

- This authorization will expire on \_\_\_\_\_.
- This authorization has no expiration date.

**I understand that payment is due at the time services are rendered. In my absence Alaska Center for Dermatology has my authorization to collect payment in the following manner:**

- Bill my credit card on file. (Please ensure card on file is current).
- Call me at the following number(s) \_\_\_\_\_ for payment by credit card over the phone. (We cannot take checks over the phone.)

\_\_\_\_\_  
Parent/ Legal Guardian Signature

\_\_\_\_\_  
Date