Minor Legal Guardian Consent

Patient Name: _____

Authorization for Treatment and Release of Information:

I hereby authorize Pioneer Valley Dermatology, or whomever they designate, to evaluate and treat the above named child, and to release to my insurance company any information acquired during the course of the child's examination or treatment, and to receive all payments for such examination or treatment. PVD has my permission to release any diagnostic studies, reports, etc., to a Health Care Provider involved in caring for my child.

My Signature below indicates I am the legal guardian for the patient listed above, that I have provided accurate information to the best of my knowledge and I understand and agree to the provisions above.

Signature of Parent/Legal Guardian _____Date_____

DOB of patient _____

Printed Name of Parent/Legal Guardian_____