Bee Caves Dermatology
5656 Bee Cave Rd., Bldg D, Suite 203 Austin, Texas 78746
Phone 512-329-6090 Fax 512-329-0125

Consent for Minor Patient to be Treated

Bee Caves Dermatology requires that a minor patient must be seen and accompanied by a parent or adult legal guardian at the first visit. After the initial visit, if the parent or guardian would like the minor patient to be seen unaccompanied, we must have signature authorization. Please fill out the form and fax, mail or deliver to the office.

Minor Patient Name: _____

Patient Date of Birth and Age: _____

Person giving consent for treatment

Name _____

Daytime Phone _____

Relation: check one
_____ Parent
_____ Legal Guardian
_____ Managing Conservator of the Minor

Authorization (please mark appropriate space)

_____ I hereby give my consent to have _____ seen and treated by Bee Caves Dermatology, Mary Ann Martinez, M.D. without my presence.

_____ I give authority to (check below) consent to medical treatment for the above named patient in my absence to:

_____ Educational institution in which the patient is enrolled
_____ Adult who has care / control of the patient, please specify
Name and relation _____

I give Bee Caves Dermatology the right to discuss and treat the above patient's disease of the skin, hair and nails, not limited to any prescriptions and procedures deemed necessary by Mary Ann Martinez, M.D. I give consent for treatment to begin on the date below and understand I may revoke this consent by giving written notice to Bee Caves Dermatology.

_____ _____
Signature of Parent or Legal Guardian Date