Columbia Dermatology, LLC
Jessica Burgy, M.D.
Cody Connor, M.D.
Coty Campbell, C.F.N.P.

Consent For Medical Treatment Of A Minor

Name of Patient: _____ DOB: ____/____/_____

Many times parents/guardians find themselves unable to accompany their teen or young adult children to their appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

Parent/ Guardian Name(s): _____

Telephone: Home: _____Cell: _____Work: _____

Employer: _____

I, [print name], _____, the undersigned, being the parent and/or legal guardian of the above-referenced minor, consent to and request that he/she be examined, evaluated, and treated at this office when they arrive unaccompanied. This consent shall be valid from this date forward until withdrawn by the undersigned. I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding monies due for services rendered.

_____ _____

Signature of Parent/Guardian Date

1600 Lake Murray Boulevard, Columbia, South Carolina, 29212
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