

Northwest Dermatology, S.C.

2500 West Higgins Road, Suite 1040, Hoffman Estates, Illinois 60169

Phone: 847-884-8096 Fax: 847-884-8125

Minor Patient Agreement

Name of minor patient: _____

Name of parent or legal guardian: _____

I give my consent, as legal guardian, to have the physicians of Northwest Dermatology, S.C. treat and prescribe medication for my minor child. I understand that this consent will be kept on file for all appointments and will only be voided by my written notification or at the time my child turns 18.

(Date) (Print Signature Name) (Signature of Patient or Guardian)

May we discuss the personal health information of this dependent patient with anyone else, such as another parent, step-parent, grandparent, adult child, etc.? Y N

Name of other person(s): _____

Relationship to patient: _____

When necessary, what phone number(s) do you prefer to be notified of Pathology, Laboratory, other test results, or answers to your questions?

Primary #: _____ Alternate#: _____

May we leave a message? Y N

(Date) (Print Signature Name) (Signature of Patient or Guardian)

Reviewed, no changes made. Parent or Legal Guardian Initials: _____ Date: _____

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