Howard L. Sofen, M.D.

Dermatology

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Consent to Treat Unaccompanied Minor

It may be convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal decision maker cannot be present prior to treatment. Be advised that protected health information may be shared with the designated decision maker to facilitate informed decision making.

AUTHORIZATION

I have the legal right to preauthorize Howard Sofen and Associates to treat my child/ward and I give permission to Howard Sofen and Associates to treat my child/ward to treat my child/ward for the indicated conditions over the indicated period. This authorization is valid until revoked in writing.

_____ _____
Patient's Name Date of Birth

LIMITATIONS

This authorization is restricted in the following ways (mark all that apply):

☐ **Conditions:** _____
Howard Sofen and Associates can only treat the above indicated conditions.

☐ **Dates:** _____ to _____
Howard Sofen and Associates can only provide treatment between these dates.

☐ **Procedures:** _____
Howard Sofen and Associates can only perform the above indicated procedures.

EMERGENCY CONTACT

If urgent medical care is needed, first try to contact me regarding the health care of my child at the following numbers. If you are unable for any reason to contact me, then you may rely on the designated decision maker for consent.

_____	_____	_____
Contact Name	Primary Phone	Secondary Phone
_____	_____	_____
Contact Name	Primary Phone	Secondary Phone

_____ _____
Parent/Guardian Signature Date