DERMATOLOGY ASSOCIATES OF SW WASHINGTON PLLC

JOEL DATLOFF, MD
ELIZABETH S. DAWSON, MD
LAURA BRANDT, PA-C
MARY BURNELL, MPAS, PA-C

Minor Consent

The providers and staff of Dermatology Associates of SW Washington, PLLC look forward to working with you to ensure your child receives the best dermatologic care possible.

Our clinic protocol requires the consent of a parent or legal guardian in order to provide medical services to unaccompanied children under the age of 18. A parental preauthorization consent form allows Dermatology Associates to provide routine and emergency medical treatment for your minor child when deemed necessary by the provider(s). The completed form will be placed in your child's chart for future use and will remain in effect until revoked in writing. You may request this form from any staff member of the clinic.

If your minor child arrives to the clinic unaccompanied, or in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. If the minor does not have consent for treatment the appointment will be rescheduled.

Under Washington State law, minors have the right to consent to certain medical services without a parent or legal guardian's consent. A minor may consent to medical care:

- If the minor is emancipated (legally independent) or married to someone at or above age 18.
- In the event emergency care is necessary.
- For birth control and pregnancy-related care at any age.
- For outpatient drug and alcohol abuse related treatment beginning at age 13.
- For outpatient mental health treatment beginning at age 13.
- For sexually transmitted diseases, including HIV, beginning at age 14.

If a minor consents to medical treatment or care as allowed by law, he or she can request confidentiality for that aspect of care which would prohibit us from releasing this information to anyone, including a parent or legal guardian, without the minor's express written permission.

If you have questions regarding any of the information on this letter, please contact a member or our management team at 360-254-5267.

Sincerely,

Dermatology Associate of SW Washington, PLLC

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Parental Preauthorization for Medical Care of a Minor

I (we) authorize Dermatology Associates of SW Washington, PLLC to provide routine and emergency medical treatment when deemed necessary by a provider to the minor patient listed below:

Minor's Name: _____ DOB: _____

Please try to contact me (us) regarding the healthcare of my (our) minor at the following number(s):

Parent/Guardian's name: _____ Ph.: _____

Parent/Guardian's name: _____ Ph.: _____

Other (relationship to patient): _____Ph.: _____

NOTE: If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc…) is in place, please explain in the space below with your signature, printed name, and phone number.

_____

_____

_____

_____

Parent/Guardian's Signature: _____ Date: _____

Printed name: _____ Ph.: _____

Relationship to patient: _____