



Date: _____

I, _____ (parent/legal guardian for the minor child, _____) give my permission for the aforementioned child to be seen and treated by Athens Dermatology Group providers and staff. This is valid for one year from this date; or until child reaches 18 years of age; or this permission is canceled by parent/legal guardian by certified letter. After 12 months this document must be renewed for the child to continue to be seen without parent/legal guardian present. Please keep in mind that all updated paperwork (required to be completed annually) must be completed by the parent/guardian. Paperwork can be accessed via our website (athensdermatologygroup.com/patient-forms). Completed and signed paperwork can be sent with patient.

X **Printed name** (of parent/guardian): _____

X **Signature**: _____

NOTARY SEAL

Subscribed and sworn this _____ day of
_____, 2020.

X _____

NOTARY PUBLIC