PARENTAL INFORMED CONSENT

Date:_____

Minor Name_____Minor Date of Birth_____

I give permission to Family Dermatology to treat my child.

I understand that during the course of treatment to my child unforeseen conditions may occur that may necessitate biopsy(s) to be taken by shave, punch, and/or excision and/or cryosurgery.

I consent to the disposal of any tissue which is removed in accordance with accustomed practice and procedure sent to histological examination.

To document and follow the course of treatment, I give permission to have photographs taken. Photographs are part of the medical record and are confidential I nature. I also grant permission for the judicious use for medical education purposes if identity is withheld.

Emergency Contact Information for Parents/Guardian:

Where/How can you be contacted in case of emergency?_____

Phone:_____

Parent/Guardian Information:

Name:_____Phone:_____

Drivers Lic#:_____

Parent/Guardian Signature:_____Date:_____

***This consent will expire (1) year from date signed

Family Dermatology

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

☐ I hereby authorize ***Family Dermatology*** to request my medical records from:

☐ I hereby request my records to be released to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates as specified:

_____

☐ Other: _____

In addition, I authorize the release of the following records:

☐ Yes ☐ No Sexually transmitted disease and HIV results/testing, whether negative or positive, to the person(s) listed above.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

DEFINITION: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient Signature: _____ Date Signed: _____