Advanced Dermatology Assoc
1259 S Cedar Crest Blvd., Suite 100
Allentown, PA 18103-6373

Telephone: **610-437-4134**

VIDEO VISIT CHILD AUTHORIZATION FORM

I, _____, the parent and/or legal guardian of
(Name of Parent/Guardian)

_____, hereby authorize
(Name of Patient)

_____ to accompany _____to his/her
(Name of Responsible Person) (Name of Patient)

appointment.

I do hereby consent to the examination and/or treatment of _____.
(Name of Patient)

This authorization:

____ effective only for date of service _____

____ effective from _____ to _____

____ effective until revoked by me in writing

_____ _____
Guardian Signature Date