TDA

TREIBER DERMATOLOGY ASSOCIATES

EXCELLENCE IN DERMATOLOGY

175 Purchase Street
Rye, New York 10580

Phone: 914-967-2153
Fax: 914-967-0453

I am the parent or legal guardian of the minor patient listed below. I authorize **Treiber Dermatology Associates** to evaluate and treat my child in my absence. I understand that I will be responsible for any charges incurred for the visit and that I may be contacted for consent if additional procedures, prescriptions, or treatments are recommended.

I hereby give permission for my child to receive medical evaluation and treatment from **Treiber Dermatology Associates** without my presence at the time of service.

This consent includes, but is not limited to:

- General dermatological examination and evaluation
- Prescription of medications if necessary
- Minor procedures (e.g., acne treatment, cryotherapy, wart removal)
- Communication of findings with the minor (if deemed appropriate)

☐ I would like to be contacted prior to any procedures being performed.

☐ I authorize treatment without prior phone contact.

This consent remains in effect until (choose one):

☐ **Specific date: _____**

☐ **Until revoked in writing by the parent/guardian**

Minor's Information

- **Full Name of Minor: _____**
- **Date of Birth: _____**

Parent/Guardian Information

- **Full Name: _____**
- **Phone Number: _____**
- **Date: _____**
- **Parent/Guardian Signature: _____**