

**Dermatology and Laser Institute of Colorado, P.C.**  
**9695 S Yosemite St, Ste 120**  
**Lone Tree CO 80124**  
**Fax: 720-344-0296**

**PARENTAL PRE-AUTHORIZATION FOR MEDICAL CARE TO CHILDREN**

For families who are ongoing patients of Dermatology and Laser Institute of Colorado, P.C., it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

I (we) request and authorize Dermatology and Laser Institute of Colorado, P.C. and its personnel to deliver medical care to my (our) children listed below: (please print)

_____ Name	_____ Date of Birth
_____ Name	_____ Date of Birth
_____ Name	_____ Date of Birth

If needed, I (we) can be contacted regarding health care of my (our) children at the following phone numbers:

_____ Name of Parent / Legal Guardian	_____ Phone- Home / Office / Cell
_____ Name of Parent / Legal Guardian	_____ Phone- Home / Office / Cell
_____ Other-List Relationship	_____ Phone- Home / Office / Cell

_____ Signature of Legal Guardian	_____ Date
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\_\_\_\_\_  
Print Name and Relationship

**NOTE:** If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain in the space below with your signature, printed name, and phone number at which you can be contacted.

\_\_\_\_\_  
\_\_\_\_\_