Coastal Cosmetic Center

PARENTAL AUTHORIZATION FOR CONSENT FOR TREATMENT OF A MINOR

I/We, _____, am/are the parent(s) and/or legal guardian(s) of the following minor child. (Legal guardian must present documentation supporting rights.)

Name: _____ DOB: _____

I/We hereby authorize any of the following individuals to bring my/our child in for care within Coastal Cosmetic Center/Coastal Surgery Center.

Name: _____ Relation: _____

Name: _____ Relation: _____

I/We consent to any and all medical care and attention for the child that is deemed necessary and appropriate by a physician licensed in this state. The consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care.

I/We further agree to reimburse the healthcare provider for the cost of rendering these services. The child is covered under the following healthcare plan:

Insurance carrier: _____

The following information is provided to assist in this care:

Primary Care Physician: _____

Phone number: _____

Parent/Guardian Signature: _____

Relation to Child: _____

Date: _____

Witness: _____ Date: _____

Updated: 6/2025