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Consent to permit an individual(s) other than parent or legal guardian to accompany minor child.

I, _____ hereby authorize the following individual(s) to accompany my child to Renew Family Dermatology for the provision of medical services, and to view or discuss my child; Protected Health Information. Any changes must be made in writing.

Name _____ Relationship _____

Name _____ Relationship _____

Consent to treat unaccompanied minor.

I, _____ request and authorize Renew Family Dermatology and its personnel to deliver medical care to my minor child(ren) listed below.

Name _____ Date of birth _____

Name _____ Date of birth _____