GREG K. SAKAMOTO, M.D.
DERMATOLOGY

QUEENS PHYSICIANS OFFICE BLDG III
550 S BERETANIA STREET, STE 603
HONOLULU, HI 96813
PH: (808) 447-7454 FAX: (808) 447-7456
WWW.SAKAMOTODERMATOLOGY.COM

# AUTHORIZATION TO TREAT A MINOR CHILD NOT ACCOMPANIED BY PARENT OR LEGAL GUARDIAN

PATIENT (NAME OF MINOR UNDER 18) :_____ DATE OF BIRTH:_____

TO: OFFICE OF GREG K. SAKAMOTO, MD LLC

**Please initial the applicable statements below:*

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____ Initials I authorize the following individuals (18 years or older) to accompany my child to your office to seek medical treatment (which includes sharing medical information regarding child), and provide consent for such treatment:

Name:_____ Relationship:_____

Name:_____ Relationship: _____

Name: _____Relationship:_____

I understand that my **minor child (under the age of 14)** will not be seen by physician unless accompanied by a parent, legal guardian, or an individual listed above.

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____ Initials I permit my **teenage child (14 years and older)** to attend his/her appointment alone without my presence and authorize treatment for my child. This includes providing a history of present illness/condition, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment, or prescription(s) to the parent or legal guardian listed below. I agree to be available by phone and to be financially responsible for all co-pays, coinsurance, and deductibles.

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_____
Print Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date

Rev.5/2017