Galaria Plastic Surgery and Dermatology, PLC
24805 Pinebrook Rd. Suite 105
Chantilly, VA 20152

Authorization to Consent to Health Care for a Minor

I am the custodial parent having legal custody of ________________________________, a minor child, date of birth ___________________. I authorize my child to consent to any medical treatment and/or procedures provided to the health care of the minor child at Galaria Plastic Surgery & Dermatology, PLC. This consent shall be effective on ________________. By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full importance of this grant. I understand and agree that I am liable for any and all charges incurred by the treatment of the above patient.

Limitations on such consent and treatment are as follows (if none write none on the line below).

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This consent has the following time limitations (if none write none on the line below).

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Custodial Parent Contact Information (please print):

Custodial Parent Name	Work Phone Number
Home Phone Number	Mobile Phone Number
Custodial Parent Signature	Date