PATTI K.MURAKAMI ENDO, M.D.

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY

Please complete and return signed via fax (808) 877-4363
or return in the mail prior to the patient's appointment

AUTHORIZATION FOR TREATMENT OF MINOR

LACKING CAPACITY TO CONSENT

PATIENT NAME____**DATE OF BIRTH** ________________
Legal Last Name First Name Middle Initial

This notice authorizes **PATTI ENDO, M.D.** to provide medical care, including examination, treatment, laboratory tests, local anesthetics and medical diagnosis if Parent/Legal Guardian/POA/Other is unable to accompany the patient.

Verbal authorization was given via telephone with ☐ Parent ☐ Legal Guardian ☐ POA ☐ Other __________________________

in advance of any specific diagnosis and/or treatment in order to avoid delay in providing such treatment as is deemed necessary by **PATTI ENDO, M.D., Inc.**

This authorization will remain in effect unless a written notice is given or until the minor reaches eighteen years of age. *(Please check appropriate patient representative box below).*

PREFERRED PHARMACY: ____

____
PRINT name of ☐ Parent ☐ Legal Guardian ☐ POA ☐ Other

____
Signature of ☐ Parent ☐ Legal Guardian ☐ POA ☐ Other

(________)____________________________________
Contact telephone number

____
Date

1830 Wells Street, Suite 102 Wailuku, Hawaii 96793-2365
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