Carolinas Dermatology and Plastic Surgery 1706 St. Julian Place Columbia SC 29204 803.771.7506(Ph)

Request to add responsible party for Facility Patients

Patient Name: ________________________

DOB: _______________________________

Date of the appointment: __________________________

I, _____________________ (responsible/legal party name) request that __________________ (name of representative) from ____________________ (name of the facility) bring the above patient to their appointment. This person has my full permission to make decisions that include any procedures, biopsies, treatment, and or medicine.

I understand that if this form is not filled out and signed prior to the patient's appointment it could result in the appointment being rescheduled.

This authorization expires in: □6 months □1 year □other (must specify): ________________

****Authorization will expire in a year from the date signed if not specified***

_____________________________________ _________________________

Patient/Responsible Party Signature Date

_____________________________________ _________________________

Witness Date

PLEASE BRING A COPY OF THIS FORM WITH YOU TO THE APPOINTMENT