

WRITTEN PARENTAL CONSENT FOR TREATMENT OF A MINOR

I, _____ (parent/guardian), hereby give my written consent to _____ (Clinic Name) to treat _____ (minor child) for routine or non-acute medical care in my absence, and in accordance with state law.

_____ (initials) I understand that parental consent is not required for all treatment services. Minors may provide consent for, including but not limited to, alcohol and substance abuse diagnosis and treatment; contraceptive services, family planning and reproductive services, screening for HIV infection and other sexually transmitted diseases; donating blood if seventeen (17) years of age. Minors are entitled to confidentiality and control the release of treatment information in situations where minors may consent to their own treatment.

_____ (initials) I understand that I can designate one or more individuals to accompany my child for services performed, and that the minor child may also present for services unaccompanied if I so choose.

_____ (initials) In the event that a life-threatening emergency exists, written parental consent may be obtained following treatment of the emergency.

_____ (initials) This written consent shall expires at the conclusion of each patient visit.

_____ (initials) I understand that it is my responsibility to update the information provided on this form.

Name (Minor Child): _____ Date of Birth: _____

Parent/Guardian: _____
(Printed Name)

Parent/Guardian: _____ Date: _____
(Signature)

My child may be:

[] Accompanied by : _____
(Printed Name)

(Printed Name)

**Medical treatment may be discussed with the appointed designees named above.*

[] Unaccompanied by an adult, and may present to clinic on their own.