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Obstetrics & Gynecology

Consent For Treatment For A Minor

Patient Name: _____ Date of Birth:_____ Date:_____

1. I, the undersigned, parent/guardian of _____, a minor, do hereby authorize and direct _____, MD and their staff to provide ongoing routine and emergency health care. This consent shall remain effective until _____ or until revoked on writing.

2. The patient has been deemed qualified to consent to her own health care services. Emancipation or legal exception has been established based on the following:

   _____ Emancipation, self –supporting, free of parental care, custody and control
   _____ Married or previously married minor
   _____ Family planning services
   _____ Diagnosis and/or treatment for venereal disease
   _____ Under the influence of a dangerous drug or narcotic
   _____ Meets mature minor criteria
   _____ Other (explain) _____

   _____ _____ _____ _____
   Provider Date Patient Name Date

3. Due to the following situation, administrative/legal approval has been obtained for _____, by, _____.
   Treatment/Procedure Provider

   _____ Unavailable parents/guardian
   _____ Abandoned minor

4. Telephone consent
   - Consent by telephone may be obtained when prompt treatment is needed or desirable if an adult patient is unable to give consent or the patient is a minor.
   - Telephone consents require two witnesses.
   - Whenever possible, telephone consents should be followed up with a signature or fax. The fax should be attached.

   _____ _____ (____)_____ _____
   Name Relationship Telephone Date

   _____ _____ _____ _____
   Witness Date Witness Date