



GyneMedic

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
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3. Due to the following situation, administrative/legal approval has been obtained for

Treatment/Procedure	by, Provider
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- _____ 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
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Witness	Date	Witness	Date
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