

**Authorization to Consent to Medical Services for a Minor Child**

**Under 19 years of age**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that I am the parent or legal guardian of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_, a minor and that I am authorized to provide informed consent for any medical treatment provided to my child by Women’s Health Care Center. I hereby choose to exercise my right to consent to medical treatment for said minor child as follows:

\_\_\_\_\_ **Option 1**: I hereby give Women’s Health Care Center consent to provide all medical

(initial) services required for, or requested by, the minor child and no further consent from me will be required to provide such medical services at any time after the date of this document.

\_\_\_\_\_ **Option 2**: I hereby give Women’s Health Care Center consent to provide the following (initial) medical services required for, or requested by, the minor child as reflected by

 my initials and no further consent from me will be required to provide such medical services at any time after the date of this document:

 (please check mark which of the following)

 \_\_\_\_\_Office visits including pelvic exam

 \_\_\_\_\_Pap Smear

 \_\_\_\_\_Lab tests, including blood tests or cultures

 \_\_\_\_\_Office Procedures, including Colposcopy, Cryotherapy, Ultrasounds, etc

 \_\_\_\_\_Prescriptions/Injections, including birth control, antibiotics, immunizations, etc

 \_\_\_\_\_The placement and/or removal of intrauterine or implant device for birth control

 \_\_\_\_\_Obstetrical Services

\_\_\_\_\_ **Option 3**: Any medical services provided to the minor child shall require my consent at the

(initial) time such services are provided. I understand that I must be present at every visit

 to provide my consent for services.

I understand that I am financially responsible for any medical services provided by Women’s Health Care Center to the minor child. I further understand that my consent to treat will remain in effect until the minor child reaches the age of majority (19) or I provide written notice to the clinic that I am revoking my consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Parent or Legal Guardian Parent of Legal Guardian Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Parent or Legal Guardian Date

**\*\*\*If the Legal Guardian, you must provide the office with Letters of Guardianship\*\*\***