NORTH FLORIDA OBSTETRICAL & GYNECOLOGICAL ASSOCIATES, P.A. ("North Florida")

CONSENT FOR TREATMENT OF A MINOR

According to Florida law, a parent or legal guardian must consent to the treatment of a minor (any person under 18 years of age) except under certain circumstances. The exceptions are listed below under the Consent by Minor section. In circumstances when the minor has the legal right to consent, Florida law prohibits the release of the minor's medical records for such treatment without the minor's written consent.

CONSENT BY PARENT/LEGAL GUARDIAN

I, the undersigned, as the parent or legal guardian of ________________________________ (the "minor") have the legal authority to give consent for the treatment of this minor. I, hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any medical condition. I agree that treatment may be provided in my absence. This consent shall remain in effect unless revoked in writing.

Minor's Name________________________________ DOB________________ Relationship__________________

_____________________________________ _____________________________

Signature of Parent or Legal Guardian Date

CONSENT BY MINOR PATIENT (under limited circumstances)

I, __________________________, consent to such diagnostic, medical and/or surgical treatment by North Florida providers. I have the legal authority to consent to such treatment because I am (check one or more of the following):

- ☐ an emancipated minor (emancipated by court (must provide court order), or I do not reside with my parents and I am financially independent). I can consent to any treatment.
- ☐ married, divorced or widowed (must provide copy of court document). I can consent to any treatment.
- ☐ a mother consenting to treatment of my child. (ex: Minor consenting to her child's circumcision)
- ☐ pregnant and consenting to treatment of my pregnancy.
- ☐ consenting to treatment of sexually transmitted diseases.
- ☐ consenting to treatment related to family planning (birth control and/or pregnancy).

_____________________________________ _____________________________

Signature of Minor Patient Date

CONSENT BY MINOR FOR RELEASE OF MEDICAL INFORMATION OF TREATMENT THAT MINOR PROVIDED CONSENT

Often times we are asked to give family members or others information on test results, etc. especially if you are not available to receive them. If you would like us to give out information regarding your treatment and/or test results to family or friends, please fill in their relationship to you and their name and check which type of information each person may receive. **If you do not allow us to discuss with the person financially responsible for your treatment, you, the minor, are responsible for payment in full prior to any testing and treatment for STD, HIV, BC & pregnancy.**

Name	Relationship						
		☐ ALL INFO	☐ STD's	☐ HIV/AIDS	☐ BC	☐ PREG/AB	☐ APPTS
		☐ ALL INFO	☐ STD's	☐ HIV/AIDS	☐ BC	☐ PREG/AB	☐ APPTS
		☐ ALL INFO	☐ STD's	☐ HIV/AIDS	☐ BC	☐ PREG/AB	☐ APPTS
		☐ ALL INFO	☐ STD's	☐ HIV/AIDS	☐ BC	☐ PREG/AB	☐ APPTS

Legend: **ALL INFO**: any information on file related to you, including but not limited to STDs, HIV/AIDS, BC, PREG/AB and APPTS; **STDs**: information related to sexually transmitted diseases; **HIV/AIDS**: information related to the AIDS virus (HIV); **PREG/AB**: information related to pregnancy and/or abortion; **BC**: information related to birth control; **APPTS**: only information related to appointment times and dates

☐ **I consent to the provider sending a bill and discussing the service provided to my parent or guardian who is responsible for payment.** (checking the box provides your consent to this statement)

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions.

_____________________________________ _____________________________

Signature of Minor Patient Date

Patient Name: Inserted by system DOB: Inserted by system