Women's Care FLORIDA
North Florida Ob-Gyn

North Florida OB-GYN
CONSENT BY MINOR PATIENT

A Minor (under the age of 18) can only provide own consent under limited circumstances.

I have the legal authority to consent to such treatment <u>because I am</u> (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).

I, _____, consent to such diagnostic, medical and/or surgical treatment by North Florida providers.

_____ _____

Signature of Minor Patient Date

RELEASE OF MEDICAL INFORMATION OF TREATMENT THAT MINOR PROVIDED CONSENT

<u>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</u>

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

<u>Consent for release of information</u> – that the minor has provided consent (applicable under the six limited circumstances checked above) We are often asked to give family members or others information on test results. If you would like us to give out information regarding your treatment and/or test to family or friends, please fill in their relationship to you, their name and relationship and check which type of information each person may receive.

Name of Person	**Relationship**						
		□ ALL INFO	☐ STD's	□ HIV/AIDS	□ PREG/AB	☐ BC	☐ APPTS
		□ ALL INFO	☐ STD's	□ HIV/AIDS	□ PREG/AB	☐ BC	☐ APPTS
		□ ALL INFO	☐ STD's	□ HIV/AIDS	□ PREG/AB	☐ BC	☐ APPTS
		□ ALL INFO	☐ STD's	□ HIV/AIDS	□ PREG/AB	☐ BC	☐ 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

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

Minor Patient: _____ Date: _____

Written Patient Name:_____ Date of Birth:_____