Advanced Women's OBGYN --Consent for Treatment of Minor (less than 18 years of age)

_____ _____

Name of minor patient (please print) *Date of birth*

Consent by Parent or Legal Guardian:

By signing below, I acknowledge that I:

1. Am the parent or legal guardian of _____(Minor),
2. Have the legal authority to consent for the evaluation and treatment of this minor,
3. Authorize all diagnostic, medical and/or surgical treatment of this minor as the physicians of Advanced Women's OBGYN Associates consider appropriate for the treatment of any medical condition, and
4. Allow that treatment may be provided in my absence.

This consent shall remain in effect unless revoked in writing.

_____ _____

Name of Parent/Guardian (please print) *Relationship*

_____ _____

Parent/Guardian signature *Date signed*

_____ _____

Witness signature *Date signed*

Consent by minor:

By signing below, I acknowledge that I:

1. Consent to all diagnostic, medical and/or surgical treatment by the physicians of Advanced Women's OBGYN Associates, and
2. Have the legal authority for such consent because I am:
   - ☐ An emancipated minor (court order required)
   - ☐ Married or have been married in the past (documents required),
   - ☐ Pregnant and consenting to treatment of my pregnancy,
   - ☐ Consenting to evaluation and treatment of sexually transmitted diseases, or
   - ☐ Consenting to treatment related to contraception and/or pregnancy
   - ☐ Mother consenting to treatment of my child

_____ _____

Signature of minor patient *Date signed*

_____ _____

Signature of witness *Date signed*

Continued on next page:

Advanced Women's OBGYN --Consent for Treatment of Minor (less than 18 years of age)

_____ _____

Name of minor patient (please print) *Date of birth*

Authorization by minor to release medical information for which she has given consent:

By signing below, I give permission for the staff of Advanced Women's OBGYN to discuss my evaluation and treatment and/or test results with my parent(s)/guardian(s).

_____ _____

Please print name of parent/guardian *Relationship*

_____ _____

Please print name of parent/guardian *Relationship*

Information to include:

- ☐ All information
- ☐ HIV/AIDS
- ☐ Pregnancy
- ☐ Sexually transmissible diseases (STDs)
- ☐ Birth control
- ☐ Appointment date & time

_____ _____

Signature of minor patient *Date signed*

_____ _____

Signature of witness *Date signed*