



Under Texas Law, a minor (under age 18) CAN GIVE CONSENT FOR EXAMINATION AND TREATMENT AND CAN CONTROL RELEASE OF THEIR MEDICAL RECORD only if:

- They are on active duty with the military
- They are married
- They are 16 or older and living apart from parents & manage their own financial affairs
- They are being treated for infectious, contagious or communicable diseases reportable to TDH
- They are unmarried and pregnant
- They are being treated for sexual abuse, suicide prevention, physical abuse or chemical addiction/dependency

I hereby declare that one of the above situations applies to me and I can legally consent for my own treatment.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

**IF ONE OR MORE OF THE ABOVE CIRCUMSTANCES DOES NOT APPLY TO YOU THEN PARENTAL CONSENT IS REQUIRED FOR YOUR EXAMINATION AND TREATMENT. PLEASE COMPLETE THE FORM BELOW**

**CONSENT FOR TREATMENT & CONFIDENTIALITY AGREEMENT FOR MINORS**

**PARENT:**

I, \_\_\_\_\_(parent/guardian), allow \_\_\_\_\_(patient), to enter a confidential patient-physician relationship. I understand that she can make independent health care decisions, but that my input and involvement will be encouraged.

\_\_\_\_\_(patient) has permission to schedule appointments, consent for treatment and receive confidential reports from this office. I further understand that various lab tests may be medically necessary and accept responsibility for fees associated with those services.

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Date

**PATIENT:**

I, \_\_\_\_\_(patient), am entering a confidential physician patient-relationship with the providers of RWG (physician, nurse practitioner, nurse midwife, physician assistant). I will make an effort to communicate with my parent/guardian about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations my provider and I establish.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

Patient: initial your preference below:

\_\_\_\_\_It is my preference for RWG staff to discuss my medical records with my parent/guardian.

\_\_\_\_\_It is my preference for RWG staff NOT to discuss my medical records with my parent/guardian.

\*\*\*This consent is valid for one year.

Revised 9/2008