CTOA CENTRAL TEXAS OB/GYN ASSOCIATES

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CONSENT FOR MEDICAL TREATMENT OF MINOR

Section A or B MUST be completed

SECTION A -- CONSENT BY MINOR

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 16 or older and living apart from parents/guardian & manage their own financial affairs
- They are married
- They are being treated for pregnancy and are unmarried
- They are being treated for infectious, contagious or communicable diseases reportable to TX Dept of Health
- They are being treated for sexual abuse, suicide prevention, physical abuse or chemical addiction/dependency

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

_____ _____ _____

Printed name of Minor | Signature of Minor | Date

Patient: Initial your preference below:

_____ It is my preference for CTOA staff to discuss my medical records with my parent/guardian.

_____ It is my preference for CTOA staff **NOT** to discuss my medical records with my parent/guardian.

IF ONE OF THE ABOVE CIRCUMSTANCES DOES NOT APPLY TO YOU THEN PARENTAL CONSENT IS REQUIRED BY LAW FOR YOUR EXAMINATION AND TREATMENT. COMPLETE SECTION B or C

SECTION B -- CONSENT BY PARENT/GUARDIAN

I, the undersigned, as the parent or legal guardian of _____(minor patient) **give permission** to CTOA to provide medical treatment. This consent begins on the date below and remains in effect unless revoked in writing.

_____ _____ _____

Printed name of Parent/Guardian | Signature of Parent/Guardian | Date

*(OPTIONAL) SECTION C

CONSENT BY PARENT AND MINOR FOR MINOR TO ENTER A CONFIDENTIAL PATIENT-PHYSICIAN RELATIONSHIP

PARENT: I allow my minor child 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. She has permission to schedule appointments, consent for treatment and receive confidential reports from CTOA. I further understand that various lab tests may be medically necessary and I accept responsibility for fees associated with those services. **I will not request records/health information from the provider/office.**

_____ _____ _____

Printed name of Parent/Guardian | **Signature of Parent/Guardian** | **Date**

PATIENT: With my parent's consent, I am entering a **confidential physician patient-relationship** with the providers of CTOA (physician, nurse practitioner, 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.

_____ _____ _____

Printed name of Patient/Minor | **Signature of Minor** | **Date**

*STAFF: If Section **C** is completed - Please have minor complete the bottom portion of a **new** Release of PHI Form.*

Oakwood Women's Centre
Renaissance Women's Group
The OB/GYN Group of Austin
women health partners in Obstetrics & Gynecology
Oakwood Women's Centre at Seton Williamson
Westlake Gynecology
Wildflower OB|GYN