



CONSENT FOR MEDICAL TREATMENT OF MINOR RECEIVING CONTRACEPTION

PATIENT NAME : _____ DOB: _____ Age: _____

INSTRUCTIONS :

1. This consent form is for clients age 17 and younger and their parents/guardians seeking services which require parental consent in the state of Texas if:
 - The parent/guardian does not want to consent to each episode; or
 - The parent, managing conservator, or guardian cannot be contacted; or
 - The minor is married or emancipated or age 16 or older, living separate from a parent/guardian.
2. Complete either section A or section B. Do not complete both sections.
 - Section A** should be completed by a parent, managing conservator, guardian, or other adult (if the parent, managing conservator, or guardian cannot be contacted). See options below.
 - Section B** should be completed by a minor if they are:
 - ✓ Married; or
 - ✓ Emancipated; or
 - ✓ Age 16 or older, living separate and apart from their parents, managing conservator, and/or guardian, and managing their own financial affairs.
3. ID of consenting adult :
 - Was provided and added to medical record
 - Not provided because minor brought forms signed by their parent from home or submitted electronically

Printed Name of Person Giving Consent	Signature	Date
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STAFF Printed Name (Reviewed By)	Signature	Date
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HEALTHSERVICESNTX.ORG

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HSNT at Serve Denton
 306 N Loop 288 Suite 200
 Denton, TX 76209
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 940-591-7830 Fax

Denton South Center
 3537 South I-35E Suite 210
 Denton, TX 76210
 940-381-1501
 940-381-5249 Fax

HSNT Plano
 5501 Independence Pkwy
 Suite 110
 Plano, TX 75023
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 972-424-9117 Fax

Wylie Children's Medical Clinic
 303 Hwy 78 Suite 106
 Wylie, TX 75098
 940-381-1501
 972-429-5410 Fax

SECTION A : Consent by parent, managing conservator, guardian, or other adult

I am the (check one):

- Parent of the above-named minor.
- Managing conservator of the above-named minor.
- Guardian of the above-named minor. Proof of guardianship is required.
- Other (if the parent, managing conservator, or guardian CANNOT BE CONTACTED, complete section below) ******

Printed Names of Parent(s) or Managing Conservator/Guardian (if applicable)
******Complete this section only if the parent, managing conservator, or guardian CANNOT BE CONTACTED******

The person having the right to consent to medical treatment for the above minor (parent, managing, conservator, guardian) cannot be contacted and has not given notice to the contrary. The name of one or both parent(s)/ guardian that cannot be contacted is/are:

Printed Names of Parent(s) or Managing Conservator/Guardian (if applicable)

As per Texas Family Code Chapter 32.001, I may consent for medical treatment of the above-named minor. I am the (select one):

- Grandparent
- Adult brother or sister of the child
- Adult aunt or uncle of the child
- Adult responsible for minor under juvenile court order
- Educational institution with authorization to consent from a person having the right to consent
- Adult with care/control/possession with written authorization to consent from the person having the right to consent
- Law enforcement officer with custody of a minor in need of immediate medical treatment
- Texas Youth Commission staff

SECTION B : Consent by Minor Patient

I am (check one):

- A married minor.
- An emancipated minor.
- Age 16 or older, living separate and apart from my parents, managing conservator, and/or guardian, and manage my own financial affairs.
- A minor who is unmarried and the parent of a minor. I have custody of this minor and I am able to provide consent to the medical care for my minor.

I declare under penalty of perjury that the above information is true and correct.

Printed Name of Minor Patient

Signature

Date

I give permission for Health Services of North Texas, Inc (HSNT) to provide to the minor named above confidential medical treatment. This includes permission for the minor child named above to give informed consent for the birth control method of his/her choice, based on consultation with the HSNT health care provider. I waive my right to review and sign a consent form for the birth control method the minor chooses to use.

I consent to use and disclosure of the minor’s health information as described in HSNT’s Notice of Privacy Practices. The minor will receive a copy of the Notice of Privacy Practices and sign an attestation acknowledging they received it. I understand that the minor has the right to receive free language interpreter services as described in the Non-Discrimination Notice they will receive.

The minor will be provided a fact sheet by HSNT which lists risks, benefits and alternatives to the birth control method or other medical service. They will have a chance to review the fact sheet and will be provided an opportunity to ask questions regarding the recommended birth control method or other medical services.

No guarantee has been given to me as to the results that may be obtained from any medical services the minor may receive from HSNT. I know that it is my choice whether or not to consent for the minor’s services. I know that at any time, I can change my mind about the minor receiving birth control or medical services at HSNT.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law, and HSNT will refer the positive result.

The minor may be given referrals for further diagnosis or treatment, if necessary. I understand that if referral is needed, it is my responsibility to obtain and pay for this medical care. The minor will be told how to get care in case of an emergency.

I hereby request that HSNT provide appropriate evaluation, testing and treatment (including a birth control drug or device, if the minor requests it).

As the client's legal guardian, I give permission for the minor client to access and/or obtain copies of his/her health information without my consent and as described in the HSNT Notice of Privacy Practices. The minor will receive a copy of the Notice of Privacy Practices.

This consent begins on the date below and remains in effect unless revoked in writing. Any revocation of this consent is not effective with respect to birth control or medical services already provided, or any actions taken by HSNT in reliance on this consent.

I am aware that my minor’s confidentiality may be broken if HSNT cannot contact him/her if an abnormal test result is received or a life-threatening condition is suspected or detected.

I declare under penalty of perjury that the above information is true and correct.

Printed Name of Person Giving Consent

Signature

Date