Authorization to Consent to Medical Services for a Minor Child

Hays Women's Health

Please annotate all applicable information:

_____
(Name of Minor Child) (Date of Birth)

_____
(Name of Parent)

_____
(Name of Parent)

_____
(Name of Person Giving Consent) (Relationship to Minor)

Under Texas Law (Texas Family Code Section 32.003), a minor (under age 18) can give consent for examination and treatment only if one of the following apply (please check any that apply):

- ❑ I am on active duty with the military
- ❑ I am 16 or older and living apart from my parents and manage my own financial affairs
- ❑ I consent to diagnosis and treatment for infectious, contagious or communicable diseases reportable to TDH
- ❑ I am unmarried and pregnant or have a child for whom I have custody
- ❑ I am being treated for sexual abuse, suicide prevention, physical abuse or chemical addiction/dependency
- ❑ I am serving a term of confinement with the Texas Department of Criminal Justice

I hereby declare the above marked situation(s) apply to me and I can legally consent for my own treatment.

Name: _____ Date: _____

IF ONE OR MORE OF THE ABOVE STIPULATIONS **DOES NOT** APPLY TO YOU THEN THE FOLLOWING CONSENT IS REQUIRED FOR YOUR EXAMINATION AND TREATMENT.

I _____, certify that I am the parent or legal guardian of the above-named minor child and that I am authorized to provide informed consent for any medical treatment provided to my child by Hays Women's Health. I hereby choose to exercise my right to consent to medical treatment for said minor child as follows:

******Choose only one option below******

_____ I hereby give Hays Women's Health consent to provide all medical services required for, or requested by, the minor child and no further consent from me will be required to provide medical services at any time after the date of this document.

_____ Any medical services provided to the minor child shall require my consent at the time such services are provided.
Parent or Guardian required to be present at all visits when this option is selected

I understand that I am **financially responsible** for any medical services provided by Hays Women's Health to the minor child. I further understand that my consent to treat will **remain in effect for one year from date of my signature** below or I provide written notice to this clinic that I am revoking my consent. I acknowledge that any request for medical records must be made in writing and may be denied under "therapeutic privilege".

_____
Printed name of Parent or Legal Guardian

_____
Signature of Parent or Legal Guardian Effective Date

*****This consent is required to be renewed one year from effective date*