Children's Medical Group™

A member of Children's Hospital and Health System.

Minor's Consent for Confidential Health

I, the undersigned, consent to and authorize the evaluation and treatment/test(s) ordered by my Children's Medical Group Physician. They have been explained to me and I understand:

- the purpose of the evaluation, treatment and/or test(s);
- the risks, benefits & alternatives, if any;
- that the results of the evaluation, treatment and/or test(s) will be released to the person named below. Any other release, to my parents or others, will require a specific and additional written consent.
- that CMG has my consent to bill my parent's insurance or other 3rd party for these services.

Evaluation and Treatment	Evaluation, Treatment or Tests to be done/released (Please check)	Consent Requirement
Contraceptive Care		Minor must consent *(parent/guardian consents if minor is medically incapable)*
Sexually transmitted diseases (STD's)		Minor must consent *(parent/guardian consents if minor is medically incapable)*
HIV test		<14, legal guardian must consent >14, minor must consent, *****Must check HIV consent in Epic**
Pregnancy testing		Minor must consent *(parent/guardian consents if minor is medically incapable)*
Alcohol and drug testing		<12, legal guardian must consent >12, minor must consent

I voluntarily consent to the evaluation, treatment, and or ordered tests and authorize release for the tests indicated above.
I understand the contents of this form and my questions were answered to my satisfaction.
I understand that the Patient/Family Rights and Responsibilities are made available to me by being posted at each Children's Medical Group location.
Medical records may be shared with health providers, insurance companies and CHHS for treatment, payment and health care operations
I am legally able to consent and give my permission for treatment. My signature below indicates I have provided accurate information to the best of my knowledge and I understand and agree to the provisions above. My consent is good for one year.

_____ Date

_____ Signature of Patient or Parent/Guardian

_____ Witness

_____ Name (please print) of Patient or Parent/Guardian

Release results to: me ☐ my parents/guardian ☐

Name: _____ Relationship: _____

Address: _____

City/State/Zip _____ Phone # _____