SOUTH AUSTIN MEDICAL CLINIC

Authorization for a Parent to Consent Medical Treatment of a Minor

This authorization allows the person below, who is not the parent of my minor child under the age of 18, to consent treatment for my child from a South Austin Medical Clinic, PA, provider. I understand that unless an exception to the law allows a minor to consent to his/her own treatment, South Austin Medical Clinic, PA must have consent from a parent, legal guardian or managing conservator for the minor to be seen by a doctor, unless I authorize a person over the age of 18 to consent treatment for my minor child.

Child's Full Name: ____
First Name Middle Initial Last Name Date of Birth

When I am unable to accompany my minor child to South Austin Medical Clinic, I authorize the following individual(s) to consent to medical treatment for my minor child from his/her South Austin Medical Clinic provider.

___________________________	_____________________________	___________________________
Name	Relationship to Patient	Duration of Consent
___________________________	_____________________________	___________________________
Name	Relationship to Patient	Duration of Consent

The nature of the medical treatment to be given under this authorization is for preventive care, urgent care, or acute care problems beginning on the date this authorization is signed. <u>I understand that even if I sign this authorization, South Austin Medical Clinic will not be able to perform any invasive procedures unless a parent, legal guardian, or managing conservator accompanies the minor to their appointment</u>. If such services need to be performed, another appointment will need to be scheduled in which the parent, legal guardian, or managing conservator must be in attendance.

I specifically authorize the individual(s) listed above to also give consent for my minor child to receive recommended or scheduled immunizations. **I understand that I am required to give this individual(s) sufficient and accurate medical history and other information about my minor child and his/her family for whom the consent is given to determine the risks and benefits inherent with the immunization and to determine whether immunization is advisable.* Please Initial: Yes________ No________

I understand that there are certain circumstances where a minor can legally consent to his/her own treatment without parental consent including, but not limited to treatment for: the diagnosis and treatment of an infectious, contagious, or communicable diseases that are reportable to the Texas Department of State Health Services (DSHS), treatment related to pregnancy, treatment for drug or chemical use, counseling for suicide prevention , chemical addiction or dependency, or sexual, physical, or emotional abuse.

I specifically give consent for my minor child, who is **<u>16 years or older</u>**, to consent to his/her own medical care even when he/she is not accompanied by an adult. Please Initial: Yes________ No________

I understand that payment will be collected at the time of the service by the adult presenting the minor for treatment, or the minor if he/she is seen without an adult present.

I have read, fully understand and accept the terms of this authorization.

This authorization is valid until my minor child reaches the age of 18, unless I revoke it prior to that time, by providing written notice addressed to South Austin Medical Clinic, PA

____	____________________	___________________
Parent, Legal Guardian, or Managing Conservator Signature	Relationship to Patient	Date