PLANNED PARENTHOOD OF GREATER TEXAS

CONSENT FOR MEDICAL TREATMENT OF MINOR RECEIVING FAMILY PLANNING SERVICES

Minor's information		
Full 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, 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**.
3. 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.
4. 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 manage their own financial affairs.

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.

Printed Names of Parent(s) (if known)

Printed Name of 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. 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

I give permission for Planned Parenthood of Greater Texas (PPGT) 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 PPGT 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 understand that the minor has the right to receive free language interpreter services. They must tell the staff if these services will be helpful to their understanding of the written or spoken information given during health care visits

FOR CLINIC STAFF USE ONLY	Client Name:
	DOB:
	MR#:

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The minor will be provided a fact sheet by PPGT that 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 PPGT. 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 PPGT.

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 PPGT 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 consent to use and disclosure of the minor's health information as described in the PPGT Notice of Privacy Practices. The minor will receive a copy of the Notice of Privacy Practices.

I hereby request that PPGT 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 PPGT Notice of Privacy Practices. The minor will receive a copy of the Notice of Privacy Practices.

Please note that Planned Parenthood is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of the minor's care.

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 PPGT in reliance on this consent.

I am aware that my minor's confidentiality may be broken if PPGT 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
Staff Printed Name	Signature	Date

FOR CLINIC STAFF USE ONLY	☐ Parental ID was provided and a copy was added to the medical record. ☐ Parental ID was not provided because minor brought in completed, signed form from home.

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 Client	Signature	Date
Witness Printed Name	Signature	Date

FOR CLINIC STAFF USE ONLY	Client Name:
	DOB:
	MR#: