Comprehensive OB/GYN Minor Consent to Treat

I, ___________________________________, parent/legal guardian of ____,

a minor whose date of birth is ________________, do hereby authorize **Comprehensive OB/GYN** and my daughter's assigned physician to evaluate and treat her on this _____ day of _____________20____.

I understand the care being rendered will include medical evaluation as well as surgical evaluation if necessary, diagnostic testing, which may consist of blood work sent to a third-party testing facility, in office lab work and/or diagnostic imaging such as sonogram. I also authorize hospital admission if such treatment is necessary, which may or may not require additional diagnostic imaging and/or anesthesia.

If I am not available to accompany my daughter to her scheduled appointment, I have granted the following person authority and power to consent to the evaluation and treatment as listed above.

Name ____________________________________**DOB** ________________________ **Phone** ______________________

If there are any questions or concerns I may be reached at ____.

It is understood this authorization is given in advance of any specific diagnosis, treatment or care being required, but is given to provide authority and power to render care, which the aforementioned practice and established physician, in the exercise of his/her best judgment, may deem advisable.

I hereby indemnify and hold harmless **Comprehensive OB/GYN** and their physicians, officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, successors, and heirs from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization also grants the power to release information to any third-party payers who may be responsible for part or all of the cost of the services provided.

Signature of Parent or Legal Guardian ____ **Date** ___________________

Comprehensive OB/GYN Minor Confidentiality Agreement

Parent

I, ____, (parent/guardian), allow ____(patient), to enter a confidential patient-physician relationship. I understand that she can make independent health care decisions, but that my input and involvement will be encouraged. ______________________________ (patient) has permission to schedule appointments and receive confidential reports from this office. I further understand that various laboratory tests may be necessary in medical protocols and accept responsibility for physician charges and laboratory fees.

________________________________ ______________________________
Parent or Guardian Signature Date

_________________________________ ______________________________
Physician Date

Patient

I, ______________________________________ (patient), am entering a confidential physician-patient relationship with _______________________________ (physician). I will make an effort to communicate with my parent(s) or guardian(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations my physician and I establish.

________________________________ ______________________________
Parent or Guardian Signature Date

_________________________________ ______________________________
Physician Date