LEGACY COMMUNITY HEALTH

Parental Consent for Confidential Services

Patient Name: _____ **Date of Birth:** _____

I am the (check one):

- ☐ Parent of the above-named minor.
- ☐ Managing conservator of the above-named minor.
- ☐ Guardian of the above-named minor. Proof of guardianship is required.

_____

Printed Name(s) of Parent(s) (if known)

_____

Printed Name of Managing Conservator/Guardian (if applicable)

I give permission for Legacy Community Health Services, Inc. (Legacy) 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 Legacy 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 consent to use and disclosure of the minor's health information as described in the Legacy Notice of Privacy Practices. The minor will receive a copy of the Notice of Privacy Practices and sign an attestation acknowledging they received it. I understand that the minor has the right to receive free language interpreter services as described in the Non-Discrimination Notice they will receive.

The minor will be provided a fact sheet by Legacy 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 Legacy. 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 Legacy.

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

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 Legacy in reliance on this consent.

I am aware that my minor's confidentiality may be broken if Legacy 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