NORTH
SCOTTSDALE
FAMILY MEDICINE

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CONSENT FOR TREATMENT FOR A MINOR

Patient Name: _____ Date of Birth: _____ Today's Date: _____

1) I, the undersigned parent/guardian of _____, a minor, do hereby authorize and direct _____, MD and the staff of North Scottsdale Family Medicine to provide ongoing routine and emergency health care. This consent shall remain in effect until _____ or until revoked in writing.

_____ Parent/guardian _____ Date _____ Witness _____ Date

2) The patient has been deemed qualified to consent to his/her own health care services. Emancipation or legal exception has been established based on the following:

_____ Emancipation, self-supporting, free of parental care, custody and control
_____ Married, or previously married minor
_____ Family Planning Services
_____ Diagnosis/treatment for venereal disease
_____ Under the influence of a dangerous drug or narcotic
_____ Meets mature minor criteria
_____ Other (explain): _____

_____ Clinician _____ Date _____ Patient _____ Date

3) Due to the following situation, administrative/legal approval has been obtained for _____ (treatment/procedure), by _____, Administrator.

_____ Unavailable parents/guardian.
_____ Abandoned Minor

4) *Telephone Consent*

1. Consent by telephone may be obtained when prompt treatment is needed or desirable if an adult patient is unable to give consent, or the patient is a minor.
2. Telephone consents require two witnesses.
3. Whenever possible, telephone consents should be followed up with a signature or fax. The fax should be attached.

_____ Name _____ Relationship _____ Telephone _____ Date

_____ Witness _____ Date _____ Witness _____ Date