For ARC Use: Place Patient Label Here

Authorization for a Non-Parent to Consent to Medical Treatment of a Minor

This Authorization allows the person identified below, who is not the parent of my minor child under the age of 18, to consent to treatment for my child from an Austin Regional Clinic provider when I am unable to accompany him/her to the Clinic. I understand that unless an exception to the law allows a minor to consent to his/her own treatment, the Clinic 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 to treatment for my minor child.

Child's full name ____
First Name Middle Name Last Name Date of Birth

Child's full name ____
First Name Middle Name Last Name Date of Birth

When I am unable to accompany my minor child to Austin Regional Clinic, I authorize the following individual(s) to consent to medical treatment for my minor child from his/her Austin Regional 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 preventative care, urgent care, or acute care problems beginning on the date this authorization is signed. **I understand that even if I sign this Authorization Austin Regional Clinic will not be able to perform any invasive procedures unless a parent, legal guardian, or managing conservator accompanies the minor to their appointment.** 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 disease that is reportable to the Texas Department of State Health Services (DSHS), treatment related to pregnancy, access to contraceptives, treatment for drug or chemical use, counseling for suicide prevention, chemical addiction or dependency, or sexual, physical, or emotional abuse.

I specifically give my consent for my minor child , who is **16 years or older,** 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 service by the adult presenting the minor for treatment, or the minor if he/she is seen without an adult present.

I have read, 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 to ARC addressed to the:

Privacy Officer
4515 Seton Center Parkway, Suite 215
Austin, TX 78759

____ ________________________
Parent, Legal Guardian, or Managing Conservator Signature Relationship to Patient

____
Date