

ATLANTA WOMEN’S HEALTH GROUP, P.C. (“AWHG”)

CONSENT FOR TREATMENT BY MINOR PATIENT (under limited circumstances)

According to Georgia law, a minor (any person under 18 years of age) may consent to treatment under certain circumstances. In circumstances when the minor has the legal right to consent, Georgia law prohibits the release of the minor’s medical records for such treatment without the minor’s written consent except for treatment for venereal diseases. Health providers and facilities are allowed to inform the spouse, parent, custodian, or guardian of a minor as to the treatment given or needed for a venereal disease. Such information may be given even over the express refusal of the minor.

I, _____, DOB: _____ consent to _____ (specific diagnostic, medical and/or surgical treatment to be provided by AWHG providers. I understand that I can only consent to the treatment for which I have the legal authority. For example, if I am a minor and a single mother, I can only consent to treatment for my child. I could not consent to a routine/annual exam for myself. I have the legal authority to consent to the above listed treatment because I am (check one or more of the following):

- an emancipated minor** (emancipated by court (must provide court order)). Emancipated means that I am legally released by a court from parental control and supervision. I live separate from my parents and do not receive any financial assistance from my parents. I **can consent to any treatment for myself.**
- married, divorced or widowed** (must provide copy of court document). I **can consent to any treatment for myself.**
- a mother.** I can only consent to treatment of my child. I cannot consent to treatment for myself.
- pregnant.** I can only consent to treatment of my pregnancy. I cannot consent to treatment for any other reason.
- consenting to **treatment of venereal diseases** – specifically syphilis, gonorrhea and chancroid. I cannot consent to treatment for any other reason.
- consenting to **treatment related to family planning** (birth control and/or pregnancy). I cannot consent to treatment for any other reason.

Signature of Minor Patient

Date

CONSENT BY MINOR PATIENT FOR RELEASE OF MEDICAL INFORMATION

Often times we are asked to give family members or others information on test results, etc. especially if you are not available to receive them. For any treatment that you are legally allowed to provide consent (as listed above), you can decide who may receive information regarding your treatment and/or testing. If you would like us to give out information regarding your treatment

and/or test results to family or friends, please fill in their relationship to you and their name and check which type of information each person may receive.

Please understand that if you are covered under your parent’s insurance, we must be able to release your information to the insurance company and to your parents for the treatment and/or tests to be paid. If you refuse to allow the information to be released, you will have to pay for the services in full before any services will be provided.

Name	Relationship						
		<input type="checkbox"/> ALL INFO	<input type="checkbox"/> BILLING INFO	<input type="checkbox"/> VD's	<input type="checkbox"/> BC	<input type="checkbox"/> PREG	<input type="checkbox"/> APPTS
		<input type="checkbox"/> ALL INFO	<input type="checkbox"/> BILLING INFO	<input type="checkbox"/> VD's	<input type="checkbox"/> BC	<input type="checkbox"/> PREG	<input type="checkbox"/> APPTS

ALL INFO: any information on file related to you, including but not limited to STDs, BC, PREG and APPTS; **BILLING INFO:** information necessary to obtain payment for your treatment (includes reason for treatment); **VD's:** information related to venereal diseases; **PREG:** information related to pregnancy; **BC:** information related to birth control; **APPTS:** only information related to appointment times and dates

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions.

Signature of Minor Patient

Date