Partnership
Community Health Center

MINOR CONSENT

Minor Patient name: _____
Minor Patient Date of Birth: _____

I/We, _____ (*name(s) of parent(s) with legal custody of minor patient*), state that I/we have legal custody of the minor patient named above. I/We have medical/dental decision-making authority of the minor patient and are authorized to make health care decisions on behalf of the minor patient.

I/We authorize Partnership Community Health Center providers (including healthcare professional students/residents) to provide the minor patient with emergency, urgent, and routine medical and dental care and treatment, including all diagnostic procedures.

I/We authorize Partnership Community Health Center to provide any Parent Substitute (if there is any Delegating Parental Power form on file for this minor patient) with Protected Health Information relating to the minor patient. "Protected Health Information" means all medical records and treatment records relating to the minor patient which are protected and confidential under 42C.F.R. Part 2, Wis Stat 51.30 and 146.82, the Health Insurance Portability and Accountability Act of 1996, Public Lay 104-191 ("HIPAA") and the Standards for Privacy of individually identifiable Health Information ("HIPAA Privacy Regulations"), 45 C.F.R. Part 160 and Part 164, subparts A and E.

This authorization is valid until revoked as described below or upon the minor patient reaching age of majority or until the following date _____.

Parent or legal guardian is responsible to notify Partnership Community Health Center of any changes. This authorization may be changed or revoked at any time prior to the expiration date above by providing Partnership Community Health Center with written notice. I/We are aware that any change or revocation will not be effective until after the date written notice is received.

I/We have carefully read, considered and agree with the consent form before signing it.

SIGNATURE(S) OF PARENT(S)/LEGAL GUARDIAN(S)

(*If more than one parent has legal custody of the child(ren), both parents must sign below.*)

Signature: _____ Date: _____
Name Printed: _____
Address: _____
Telephone Number: _____ E-mail Address: _____

Signature: _____ Date: _____
Name Printed: _____
Address: _____
Telephone Number: _____ E-mail Address: _____

If you would like this consent to include all vaccines, please signs and date below. Please make sure you have access to MyPartnership where you can receive the CDC Vaccine Information Sheets.

Signature: _____ Date: _____

Signature: _____ Date: _____