



Family Structure, Custody, and Consent Information

This form helps us provide safe, respectful, and legally appropriate care for your child(ren) under **Oregon law**. It reflects Southern Oregon Pediatrics' policy for divorced or separated parents and applies to all family configurations.

Child Information

- **Child's Full Name:** _____
- **Date of Birth:** _____
- **Child's phone (if applicable):** _____
- **For patients 14 and older: MyChart Access** ☐ Yes ☐ No ☐ Request enrollment
- **Full name of siblings and DOB if seen on our office**

Parent / Legal Guardian Information

Please list **all** parents or legal guardians, regardless of custody status.

Parent / Guardian 1

- **Name:** _____
- **Date of Birth:** _____
- **Relationship:** ☐ Parent ☐ Legal Guardian ☐ Other: _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **MyChart Access:** ☐ Yes ☐ No ☐ Request enrollment

Parent / Guardian 2

- **Name:** _____
- **Date of Birth:** _____
- **Relationship:** ☐ Parent ☐ Legal Guardian ☐ Other: _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **MyChart Access:** ☐ Yes ☐ No ☐ Request enrollment

(Attach additional page if needed.)

Family Structure (check all that apply)

- ☐ Married parents
- ☐ Partnered parents
- ☐ Divorced or legally separated parents
- ☐ Never married / co-parenting
- ☐ Solo parent (no active co-parent)
- ☐ Re-partnered / remarried with stepparent
- ☐ Grandparent-led family
- ☐ Resource parent(s) (foster, kinship, or DHS-involved placement)
- ☐ Other caregiver arrangement: _____



Legal Custody & Medical Decision-Making

Legal Custody Status (check one)

- ☐ No formal custody order (default)
- ☐ Joint legal custody
- ☐ Sole legal custody (**court order required**)

- **If sole legal custody:** Name of legal custodian: _____

- ☐ A court order affecting custody or access to medical information **is on file**
- ☐ No court order on file

If no court order is on file, the clinic will assume either parent may consent to routine medical care and access medical information.

Authorized Adults (Non-Parents)

The following individuals may **bring the child to appointments** and **consent to care for that visit only**.

Family responsibility: It is the family's responsibility to follow this agreement and ensure that only authorized individuals bring the child to appointments. Southern Oregon Pediatrics will **assume that the individual who presents the child for care is authorized to do so**, unless a court order on file states otherwise.

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____

- ☐ No additional caregivers authorized

Communication & Confidentiality

I understand that:

- Parents and caregivers will communicate with each other regarding patient's treatment and provider recommendations.
- Parents have legal right to access and review medical records until age of consent (14 years of age) and may do so via MyChart or requesting a release of medical records.
- All verbal & written communication is allowed to be shared with legal parents.

Initials: _____

Behavioral Health & Confidentiality (Oregon)

I understand that:

- Under Oregon law, minors may consent to certain behavioral health services.
- Providers may limit parental participation in behavioral health visits when clinically appropriate.
- Safety concerns override confidentiality.
- Behavioral Health Consultants (BHCs) in this clinic provide brief, integrated behavioral health services as part of primary care and do not provide ongoing individual psychotherapy or custody evaluations.
- Because BHC services are consultative and integrated within medical care, providers do not participate in custody disputes, provide court testimony, or conduct forensic evaluations related to custody or parenting matters.

Initials: _____

**Insurance & Financial Responsibility**

- The signing adult is the **financial guarantor**.
- Payment is due at time of service from the accompanying adult.
- The clinic cannot mediate financial disputes between parents.

Initials: _____

Parent / Guardian Agreement

By signing below, I acknowledge and agree that:

- Only the individuals listed on this form are authorized to bring my child to appointments or be present for visits unless updated in writing.
- It is my responsibility to inform the clinic of changes to custody, authorized caregivers, or legal status.
- I understand and agree to comply with clinic policies regarding consent, communication, confidentiality, and conduct.

☐ I understand and agree

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

Please inform Southern Oregon Pediatrics promptly of changes to custody, authorized caregivers, or insurance.