OBSTETRICAL & GYNECOLOGICAL ASSOCIATES OF CORPUS CHRISTI

CONSENT FOR MEDICAL TREATMENT OF MINOR

Name of Minor: _____ Birth Date: _____ Age: _____

COMPLETE SECTION I OR II (not both)

SECTION I **CONSENT BY PARENT/GUARDIAN**

Printed Name of Parent(s) if known _____

Printed Name of Guardian (if applicable) _____

I am the (check one) **____ parent** **____ guardian of above named minor.**

Complete this section ONLY if parent/guardian cannot be contacted.

The person that has the right to consent to medical treatment for the above minor(parent/guardian) cannot be contacted and has not given notice to the contrary. As per Texas Family Code Chapter 32.001, I may consent to medical treatment of the above named minor.

I am the (check one):

____grandparent ____ adult brother/sister ____ adult aunt/uncle

____educational institution with authorization to consent from a person having the right to consent

____ adult responsible for minor under juvenile court order

____ adult with care/control/possession with written authorization to consent from the person having the right to consent

I give permission for Obstetrical and Gynecological Associates of Corpus Christi to provide the minor named above confidential medical treatment. This permission includes for the minor child to give informed consent for the birth control method of her choice, based on her consultation with the physician. I waive my right to review and sign a consent form for the birth control method the minor chooses to use. This consent begins on the date below and remains in effect unless revoked in writing.

I declare that the above information is true and correct.

_____ _____ _____

Printed Name of Person Giving Consent Signature of Person Giving Consent Date

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SECTION II **CONSENT BY MINOR**

____ I am an emancipated minor.

____ I am 16 years of age or older, living separate and apart from my parents/guardian, and I manage my own finances.

I declare that the above information is true and correct.

_____ _____

Signature of Minor **Date**