

**PLANNED PARENTHOOD OF AUSTIN SURGICAL & SEXUAL HEALTH SERVICES**

**South Clinic**  
201 East Ben White Blvd.  
Suite A  
Austin, Texas 78704  
(512) 276-8000

**Surgical Center**  
201 East Ben White Blvd.  
Austin, Texas 78704  
(512) 276-8000

**North Clinic**  
9041 Research Blvd.  
Suite 250  
Austin, Texas 78758  
(512) 331-1288

Name \_\_\_\_\_  
DOB \_\_\_\_\_  
MRN # \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT OF MINOR**

Patient Age \_\_\_\_\_

*PLEASE COMPLETE SECTION A OR B*

**SECTION A - CONSENT BY PARENT/ MANAGING CONSERVATOR/ GUARDIAN OR OTHER ADULT**

- I am the (check one)     Parent of the above named minor  
                                   Managing Conservator of the above named minor  
                                   Guardian of the above named minor

Printed Name of Parent(s) (if known) \_\_\_\_\_

Printed Name Managing Conservator/ Guardian (if applicable) \_\_\_\_\_

*Complete this section ONLY if the parent/ managing conservator/ guardian CANNOT BE CONTACTED*

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

*I am the:*

- Grandparent
- Educational institution with authorization to consent from a person having the right to consent
- Adult with care/ control/ possession with written authorization to consent from the person having the right to Consent
- Adult responsible for minor under juvenile court order
- Texas Youth Commission staff
- Law Enforcement Officer with custody of a minor in need of immediate medical treatment

I give permission for Planned Parenthood of Austin Surgical and Sexual Health Services (PPASSHS) to provide to the minor named above confidential medical treatment. This includes permission for the minor child named above to give informed consent for the birth control method of her choice, based on consultation with the PPASSHS health care provider. I waive my right to review and sign a consent form for the birth control method the minor chooses to use.

**I understand that the minor has the right to receive free language interpreter services. They must tell the staff if these services will be helpful to their understanding of the written or spoken information given during my health care visits.**

**The minor will be provided a fact sheet by PPASSHS that lists risks, benefits and alternatives to the birth control method or other medical service. They will have a chance to review the fact sheet and will be provided an opportunity to ask questions regarding the recommended birth control method or other medical services.**

**No guarantee has been given to me as to the results that may be obtained from any medical services the minor may receive from PPASSHS. I know that it is my choice whether or not to consent for the minor's services. I know that at any time, I can change my mind about the minor receiving birth control or medical services at PPASSHS.**

**I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law, and PPASSHS will refer the positive result.**

**The minor may be given referrals for further diagnosis or treatment, if necessary. I understand that if referral is needed, it is my responsibility to obtain and pay for this medical care. The minor will be told how to get care in case of an emergency.**

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**I consent to use and disclosure of the minor’s health information as described in the PPASSHS Notice of Privacy Practices. The minor will receive a copy of the Notice of Privacy Practices.**

**I hereby request that PPASSHS provide appropriate evaluation, testing and treatment (including a birth control drug or device, if the minor requests it).**

This consent begins on the date below and remains in effect unless revoked in writing. Any revocation of this consent is not effective with respect to birth control or medical services already provided, or any actions taken by PPASSHS in reliance on this consent.

**I declare under penalty of perjury that the above information is true and correct.**

\_\_\_\_\_  
Printed Name of Person Giving Consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Giving Consent

\*\*\*\*\*

**SECTION B - CONSENT BY MINOR CLIENT**

- I am an emancipated minor
- I am age 16 or older, living separate and apart from my parents/ managing conservator/ guardian, and manage my own financial affairs.

**I declare under penalty of perjury that the above information is true and correct.**

\_\_\_\_\_  
Printed Name of Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Minor

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

**FACTS ABOUT MINOR CONSENT FOR MEDICAL TREATMENT IN TEXAS**

Some minors (under the age of 18) will be required to obtain consent from a parent or guardian before receiving **certain** medical services (such as birth control, Pap test or well woman exams) at our clinics.

**We CAN provide certain medical care to a minor without parental consent at any of our Austin clinics if:**

- You are requesting condoms
- You would like information about birth control
- You are requesting a pregnancy test
- You are requesting testing or treatment for certain sexually transmitted infections.
- You are on Medicaid.
- You are age 16 or 17 **and** live apart from your parents **and** manage your own finances. You will be asked to sign a form stating that these are your living arrangements.
- You are emancipated.
- Your parent(s)/guardian **cannot be contacted**. This means that you do not know how to contact your parents/guardian (you don't know where they live or you are unable to contact them). This does not apply if you just don't **want** your parents/guardian to be contacted. If your parent or guardian cannot be contacted another adult may be able to sign a consent form for you.