Planned Parenthood of Houston & Southeast Texas, Inc.
CONSENT FOR MEDICAL TREATMENT OF MINOR

Name of Minor ______________________________ Birth Date ____________ Age ______

COMPLETE SECTION A OR B

SECTION A

CONSENT BY PARENT/MANAGING CONSERVATOR/GUARDIAN OR OTHER ADULT

Printed Name of Parent(s) if known ____

Printed Name of Managing Conservator/Guardian (if applicable)___________________________

I am the (check one) ___ parent ___ managing conservator ___ guardian of the above named minor.

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 (check one):
___ grand parent ___adult brother/sister ___adult aunt/uncle
___ 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

I give permission for PPHSET 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 health care provider. 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 under penalty of perjury that the above information is true and correct.

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

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.

______________________________ ______________
Signature of Minor Date

FACTS ABOUT MINOR CONSENT FOR MEDICAL TREATMENT

SOME MINORS (UNDER THE AGE OF 18) ARE REQUIRED TO OBTAIN A CONSENT FORM FROM A PARENT/GUARDIAN BEFORE RECEIVING CERTAIN MEDICAL SERVICES AND TREATMENT.

You **DO NOT** need to have your parent/guardian sign a consent form if:

- You are on Medicaid.
- You are 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.
- You are requesting ONLY testing or treatment for certain sexually transmitted infections.
- You are requesting ONLY pregnancy testing.
- Your parent(s)/guardian CANNOT BE CONTACTED. This means that you do not know how to contact your parents/guardian or you do not know where they live or you cannot reach them by phone or letter. This does not apply if you just do not WANT your parents/guardian to be contacted. **IF YOUR PARENT OR GUARDIAN CANNOT BE CONTACTED, ANOTHER ADULT – GRANDPARENT, AUNT, UNCLE, BROTHER, SISTER - MAY SIGN A CONSENT FORM FOR YOU.**
- You request services from a Title X funded clinic. A list of Title X funded clinics can be found at http://www.plannedparenthood.org/pphset/facts-about-minor-consent-medical-treatment-28726.htm .

WE CAN PROVIDE:

- ✓ CONDOMS
- ✓ BIRTH CONTROL FOAM OR FILM
- ✓ INFORMATION ABOUT BIRTH CONTROL
- ✓ PREGNANCY TESTING
- ✓ TESTING / TREATMENT FOR CERTAIN SEXUALLY TRANSMITTED INFECTIONS

TO A MINOR WITHOUT PARENTAL CONSENT.