



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 Bay Area Obstetrics & Gynecology, P.A. to provide confidential medical treatment, including contraceptive services, to the minor named above. 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