Girls to Women
HEALTH AND WELLNESS

AUTHORIZATION AND CONSENT TO TREAT (for patients <18 years of age)

I, _____, the natural parent/legal guardian of _____ (a minor), have the legal right to consent to medical and surgical treatment for this patient. I grant my permission for treatment at Girls to Women Health and Wellness by a licensed physician, licensed nurse practitioner, and/or designees, including such personnel as the physician may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. I grant permission for treatment provided according to generally accepted standards of medical practice.

I understand that, in Texas, only physicians and clinics receiving Federal Title X funding can provide contraceptive services without parental consent. *My **initials** here indicate that I* ___**do** or ___**do not** *consent to contraceptive prescription (including emergency contraception) for my minor child if she requests it.*

This consent will be in effect from this date until minor is 18 years of age unless cancelled earlier by me in writing.

_____	_____	_____/_____/_____
Patient Name (print)	Patient Signature (adult patients only)	Date
_____	_____	_____/_____/_____
Parent/Guardian (print) (if patient is a minor)	Parent/Guardian Signature (if patient is a minor)	Date
_____	_____	_____/_____/_____
Witness Name	Witness Signature	Date

DELEGATION OF CONSENT

I hereby authorize the following individual(s):_____, whose relationship to this child is _____, to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a health care provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention, and elective as well as emergency care as specified above. This delegation shall be valid until I withdraw delegation of consent.

_____	_____	_____/_____/_____
Patient Name (print)	Patient Signature (adult patients only)	Date
_____	_____	_____/_____/_____
Parent/Guardian (print) (if patient is a minor)	Parent/Guardian Signature (if patient is a minor)	Date
_____	_____	_____/_____/_____
Witness Name	Witness Signature	Date