

MINOR TREATMENT AUTHORIZATION FOR A NON-PARENT OR UNACCOMPANIED MINOR

Patient Name _____ Date of Birth _____ MRN _____

Non-Parent Consent

This authorization allows the person identified below, who is not the parent of my minor child, to consent to treatment of my child by an Austin Regional Clinic (the "Clinic") provider when I am unable to accompany my child to the Clinic. I understand that unless an exception to the law allows a minor to consent to his/her own treatment, the Clinic must have consent from a parent, legal guardian or managing conservator for the minor to be seen by a provider, unless I authorize a person over the age of 18 to consent to treatment of my minor child.

When I am unable to accompany my minor child to the Clinic, I authorize the following individual(s) to consent to medical treatment for my minor child.

Name	Relationship to Parent	Duration of consent
Name	Relationship to Parent	Duration of consent

The nature of the medical treatment to be given under this authorization is for preventative care, urgent care, or acute care problems beginning on the date this authorization is signed. **I understand that even if I sign this authorization, the Clinic will be unable to perform any invasive procedures (other than immunizations if indicated below) or provide birth control unless a parent, legal guardian, or managing conservator accompanies the minor to their appointment.** If such services need to be performed, the parent, legal guardian, or managing conservator must be in attendance.

I specifically authorize the individual(s) listed above to also give consent for my minor child to receive recommended or scheduled immunizations, except for COVID-19. ** I understand that I am required to give this individual(s) sufficient and accurate medical history and other information about my minor child and their family to determine the risks and benefits.*

Please Initial: Yes _____ No _____

Unaccompanied Minor Consent

I understand that there are certain circumstances where a minor can legally consent to their own treatment without parental consent including, but not limited to treatment for: the diagnosis and treatment of an infectious, contagious, or communicable disease that is reportable to the Texas Department of State Health Services (DSHS), treatment related to pregnancy, treatment for drug or chemical use, counseling for suicide prevention, chemical addiction or dependency, or sexual, physical, or emotional abuse.

I am consenting to preventative and/or acute non-invasive care for my child, who is 16 years or older on _____ (date of visit) even if they are not accompanied by an adult. **Please Initial:** Yes _____ No _____

I understand that even if I sign this authorization, the Clinic will be unable to perform any invasive procedures (other than immunizations if indicated below) or provide birth control unless a parent, legal guardian, or managing conservator accompanies the minor to their appointment.

I am also consenting to recommended or scheduled immunizations, except for COVID-19 and I have provided sufficient and accurate medical history and other information about my child and their family to determine the risks and benefits.

Please Initial: Yes _____ No _____

This authorization is valid until my minor child reaches the age of 18, unless otherwise stated above or I revoke it prior to that time, by providing written notice to ARC addressed to the:

ARC Privacy Officer: 6210 E Highway 290, Suite 240, Austin, TX 78723

By signing below, I acknowledge that I have read, understand, and accept the terms of this Authorization.

Signature of Parent, Legal Guardian, or Managing Conservator

Relationship to Patient

Date