PROVIDENCE PEDIATRIC MEDICAL PARTNERS OF EL PASO

PROVIDENCE MEDICAL PARTNERS

PARENT or GUARDIAN: Please fill out ONLY if the office visit is for a minor.

CONSENT TO MEDICAL TREATMENT OF A MINOR

Date: ____________________

Parent's Name(s):____DOB: ____________________

Name of Person Giving Consent: ____

Relationship (Parent, Guardian, Managing Conservator of the child): __________________________________

Address: ____

Phone Number:_______________________(Home):____________________(Cell): ____________________

To Whom It May Concern:

I hereby give my permission for Providence Medical Partners, and its physicians, nurse practitioners, physician assistants, and other associates to examine and treat my child whose name and age is listed below:

_________________________________ who is______________years of age.
Patient's Name

In addition, in the event that I cannot be contacted, I hereby give my consent to the following individuals or institutions to consent to medical treatment for the foregoing child.

____
Names of Individuals who have care and control over the foregoing child (e.g. babysitter, grandparent)

____
Names of Institutions (School, daycare, etc.)

Consent to Counseling and Provision of Contraception. Texas permits minors to be treated for sexually transmitted diseases and pregnancy without parental consent and as such, I understand that appointments may include discussion, testing and treatment of sexually transmitted diseases and/or pregnancy issues. Texas does not, however, permit a health care provider to counsel and provide contraception to minors without parental consent except under limited circumstances. Check **Yes** or **No** as to whether you consent to the counseling and prescription of contraception for the minor whose name appears above.

☐ **Yes**, I consent to the counseling and provision of contraception to my child.

☐ **No**, I do not consent to the counseling and provision of contraception to my child.

X____
Signature of Parent, Guardian, or Managing Conservator

Witnesses to Signature Above:

______________________________ ____
Name Address

______________________________ ____
Name Address

PROVIDENCE
PEDIATRIC MEDICAL
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PROVIDENCE
MEDICAL PARTNERS

Providence Medical Partners
Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Providence Medical Partners unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Providence Medical Partners' infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids.
This disclosure is to inform you that you may be tested, at the expense of Providence Medical Partners, if any of these situations occur during your treatment period.

______________________________ ____________________
Patient's Printed Name Date of Birth

______________________________ ____________________
Patient/Legal Representative Signature Date

____
Relationship to Patient

______________________________ ____________________
Witness Date