**CONSENT FOR TREATMENT OF A MINOR**

The age of majority for the State of Nebraska is 19 years old. Treatment for services to anyone under the age of 19 must have the consent of a parent or legal guardian.

I am the parent or legal guardian of _____, date of birth: _____, a minor. I am legally authorized to provide informed consent for her. If I am unable to accompany my daughter to a medical appointment, I want New Life Clinic to:

Choose only **one** of the options below:

1. _____ Call me for any and all needed consents.
2. _____ The practice can provide the medical services I initial below without obtaining further consent from me. I understand that if I initial a medical service, no further consent from me will be needed for the medical service. Please indicate your consent by initialing as appropriate:

    _____ Routine office visits, including annual pelvic exams, pap smears, breast exams

    _____ Laboratory tests, including blood test, or cultures

    _____ Office Procedures, including colposcopies and ultrasound

    _____ Prescriptions/injections, including birth control, antibiotics, etc.

    _____ Prenatal care/obstetrical services

3. _____ The practice can provide all medical services required by or requested by the minor with her consent. No consent from me for those medical services will be needed. A confidential relationship between the minor and the practice will be created. No information about these medical services will be provided to me by the clinic or its providers unless authorized by the minor.

I understand and agree the (1) I am financially responsible for all medical services provided by the practice to the minor; (2) any consent I provide in this document will be effective until the minor is age 19, is married, is emancipated, or I provide written notice to the practice to revoke my consent; and (3) a minor may consent to some medical care under state law, such as treatment of STDs, and can control access to and the release of her medical records for that care apart from any consent in this document.

**Patient Name: _____** **Date of Birth: _____**
(Print) MM/DD/YYYY

**Parent/Guardian Name: _____** **Relation: _____**
(Print)

**Parent/Guardian Signature: _____** **Date: _____**