## Minor's Consent For Confidential Services

**Directions:** Check the box after you read and understand each section.

- I understand that if I am 17 years old or younger and I understand my actions, I can get help with: testing and treatment for drug and substance abuse, sexually transmitted diseases, pregnancy testing, and reproductive health and birth control education and referrals. I do not need permission from my parent(s) or guardian. My health care provider does not need permission from my parent(s) or guardian.

- I understand that if I am 14 years of age or more, I can get limited outpatient mental health services without permission from my parent(s) or guardian. I can’t have more than 12 visits in 4 months. This help does not include medications.

- I understand that I have the right to refuse treatment, or to come back at a different time, unless threat or harm to myself or others exist.

- I understand that my health care provider will not tell my parent(s) or guardian about my treatment unless:
  - My health care provider believes there is a medical reason to do so, but my provider will first talk with me before telling my parent(s) or guardian.
  - My health care provider believes I may harm myself, but first my provider will tell me that they are going to tell my parent(s) or guardian.
  - I threaten to hurt someone else, and if the health care professional believes I will hurt the person, health care professional must tell the other person and the police. I understand that the health care professional will talk to me about the threats but will tell my parent(s) or guardian.

**Telemedicine Services:**

- I understand that I may receive care through telemedicine services. The limitations of a telemedicine visit include the possibility of not being able to pick up conditions found during a complete physical exam. There may also be technical difficulties like a lost connection or interruption.

**Notice of Privacy Practices Acknowledgement:**

- I have been given/offered the Michigan Medicine Notice of Privacy Practices.

- My questions, if any, have been answered. I have read the information in this form. I understand the information.

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**Printed Name of Patient**  
**Signature of Patient**  
**Date (mm/dd/yyyy)**

I have discussed all of the information in this form with the patient. I have answered their questions and am satisfied they understand the information.

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**Explained and Obtained by (Printed Name)**  
**Signature**

**Date:**  
**Time:**

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