MICHIGAN MEDICINE Regional Alliance for Healthy Schools **Minor's Consent For Confidential Services**	NAME: MRN: DOB:

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.

_____	_____	_____/_____/_____
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.

_____	_____
Explained and Obtained by (Printed Name)	Signature

Date: _____/_____/_____ (mm/dd/yyyy) Time: _____ A.M. / P.M.

31-10003	VER: A/23 HIM: 12/23	Original - Medical Record Copy – Patient		Consent – Procedure / Treatment / Evaluation