All About Women
Health Associates, Inc.

Minor Treatment Authorization

This form gives my legal consent for treatment of my child by ***All About Women Health Associates.***

I ________________________________, do herby state that I am the parent/legal guardian of
Name of parent/guardian

_________________________________ a minor born on ___________________________________.
Patients Name　　　　　　　　　　　　　　　　　　Date of Birth

I consent to the physical and pelvic exams, medical treatment and other tests, of this minor child by ***All About Women Health Associate,*** to the above named minor under the supervision and on the advice of a duly licensed provider during the period of my absence.

_________________________________　　　　_________________________________
Parent/Guardian Signature　　　　　　　　　　Date

_________________________________　　　　_________________________________
Witness　　　　　　　　　　　　　　　　　　　Date

Minor Consent

I understand that it is my right to limit or designate who has access to my health information. No information will be released directly to any one person without my written consent or court order. However, if my healthcare costs are paid for by my parent/guardians insurance, the insurance may disclose some information during the billing process. The only way to eliminate the possibility that the insurance company reveal some information is to **NOT** bill the insurance company. In this case, I may pay directly for my health care costs.

_________________________________　　　　_________________________________
Minor　　　　　　　　　　　　　　　　　　　　Date

_________________________________　　　　_________________________________
Witness　　　　　　　　　　　　　　　　　　　Date