23702 U.S. Highway 80 East
Statesboro, Georgia 30459
(912) 489-4090
Fax (912) 764-5028
www.familyhealthcarecenter.com

Family Health Care Center

Minor Patient Care Policy

Minor Patient Name: _____ Date of birth: _____

Thank you for choosing Family Health Care Center to provide healthcare to your minor. In order to remain compliant with HIPAA rules and regulations, Family Health Care Center has adopted the following policy regarding treatment of a minor:

All minor patients must be accompanied by a legal guardian/caretaker when coming to the office for treatment, unless the patient is coming in for reproductive health, or the office staff has received written authorization to treat the patient in the form of the Consent for Minor Patient to be Treated document.

Any lab results/procedures regarding reproductive health of a minor are protected by law and may not be disclosed without express consent of the minor patient. Therefore, lab results will not be disclosed over the phone to anyone but the patient, unless consent to release the results have been documented in the patient's chart by the treating provider.

If consent has not been given to release results over the phone, then an office visit with the minor patient and guardian must be scheduled to discuss results with the treating provider. For the health of the patient, treatment for any reproductive diseases/conditions that may have been uncovered during testing/procedures may begin prior to the office visit to discuss results with legal guardian/caretaker.

Family Health Care Center requires that a minor patient be seen and accompanied by a parent or legal adult guardian at the initial visit. If the parent or guardian would like the minor patient to be seen unaccompanied for any subsequent visits we must have signature authorization. Please fill out the form in its entirety and fax, mail, or deliver to the office.

Person giving consent for treatment:

Name: _____ Daytime Phone: _____

Relation (check one):

_____ Parent _____ Legal guardian _____ Caretaker

Authorization:

I give my consent to have _____ seen and treated by Family Health Care Center without my presence. I give Family Health Care Center the right to discuss and treat the above patient's disease, not limited to any prescriptions and procedures deemed necessary by providers at Family Health Care Center. I give consent for treatment to begin on the date listed below and understand that I may revoke this consent by giving Family Health Care Center written notice.

Parent/Guardian Signature _____ **Date**_____

**this form has no expiration date unless given written notice to discontinue.