Catherine's HEALTH CENTER

Minor Consent

Name: _____ Sex: M/F Birth date: _____
Last First

Address: _____ Zip: _____ Telephone: _____

Race (Circle one): American Indian/Alaskan Native, Asian, Black Hispanic/Latino, Black Non-Hispanic/Latino, Mixed Race, White Hispanic/Latino, White Non-Hispanic/Latino

Preferred Language: ☐ English ☐ Spanish ☐ Other (specify) _____

Do you have health insurance? (Circle one) Yes No Unsure

If you do, please circle one of the following: All Kids / Medicaid / HMO / PPO

Minor Consent for Health Care and Confidentiality Policy

I agree to receive health services at Catherine's Health Center. According to Michigan law, Persons from **12 to 17 years** of age can consent to receive certain health services including: birth control, pregnancy testing, STI testing and treatment, HIV testing, pregnancy related care, and substance abuse treatment. Patients **14 to 17 years** of age can obtain up to 12 outpatient visits, or 4 months of outpatient mental health counseling.

As I am under the age of 18 years and not legally independent from my parents, I understand that this consent applies only to the services listed above. I also understand that I may withdraw my permission at any time.

As a patient of Catherine's Health Center, information about me will not be released to anyone outside of Catherine's without my permission. This means that they will not talk about me to my parents, teachers, police, or anyone else, unless I say that it is OK.

The following are a few exceptions. They may have to tell someone if:

1. An injury or accident happens on school property.
2. I tell them that I am being physically or sexually abused.
3. I am under age 12 and have been sexually active.
4. I am age 14 or under and currently pregnant.
5. I have done harm or could do harm to myself or someone else.
6. The provider may choose (but is not obligated) to tell the parents about any care provided to the minor patient, for a compelling medical reason

I understand that Catherine's Health Center may not inform my parent or guardian of the fact that I am receiving these services without my consent. Should the Catherine's Health Center staff determine to notify my parent or guardian for reasons of safety, **I understand that the staff member will make every attempt to notify me first.**

Just as the staff at Catherine's agrees to protect my confidentiality, I agree to respect the confidentiality of all other patients that I may see at Catherine's. This means that if I see another student/patient in the health center and/or hear information about someone that may be personal, I agree to keep that information to myself and tell no one else.

Signed _____ Date_____

Witness _____ Date_____