Consent to Treat Minor Child

AUTHORIZATION FOR CARE WHEN MINOR IS NOT ACCOMPANIED BY PARENT OR LEGAL GUARDIAN

Clinic Location:		**Clinic State:** ☐ Illinois ☐ Indiana

This clinic operates in both Illinois and Indiana. Minor-consent law differs between the two states for certain confidential services described in Section 1. Staff should reference the footnotes below for state-specific rules based on the clinic state selected above.

1. ACKNOWLEDGEMENT

I acknowledge that Midwest Express Clinic requires permission from a minor child's parent or legal guardian before providing medical services when the child is accompanied by someone other than a parent or legal guardian or presents unaccompanied. When a parent or legal guardian is not immediately available and advance consent has not been provided, staff must obtain permission, and treatment may be delayed pending that permission, except where emergency care is required or where the minor is authorized to consent independently under applicable law.

Completion of this form does not delay or limit emergency care. If an individual presents with an emergency condition, Midwest Express Clinic will provide immediate first aid and medical care within its capabilities regardless of ability to obtain consent or payment, consistent with applicable law permitting treatment without consent in an emergency, and will activate emergency medical services as necessary to facilitate moving the patient to the appropriate level of care.

A specific treatment, medication administration, or procedure performed during a visit still requires separate verbal or written consent at the time of the visit, from either the parent/legal guardian, the person authorized below, or the minor patient where the minor is independently authorized to consent.

Independent minor consent rights. This form does not limit any right a minor patient may independently have under state law to consent to certain confidential medical services without parental involvement. Such rights may include, but are not limited to, care related to sexually transmitted infections , pregnancy and contraception , mental health, or substance use-related treatment , subject to age and other conditions specified by applicable state law. Minors who have been emancipated by a court or who are legally married may consent to their medical care without limitation. Staff will verify and document the applicable legal basis for minor consent before providing services under this section.[4]

2. PATIENT INFORMATION

Patient's Name		**Date of Birth**	
Address			

3. PARENT / LEGAL GUARDIAN OF RECORD

Name		**Relationship:** ☐ Parent ☐ Legal Guardian*
Address/Phone		

**If Legal Guardian, a copy of the court order or guardianship documentation must be scanned to the patient chart before this form is accepted.*

4. DESIGNATED AUTHORIZED ADULT(S)

The following person(s) have permission to authorize routine medical care and/or sports or school physical examinations for my child, and to sign related consents, acknowledgments, and financial responsibility forms on my behalf. Each person listed must present valid government-issued photo identification at every visit; staff will record the ID at check-in (Section 9). IF NOT APPLICABLE, NOTE "N/A" BELOW.

Name	
Relationship to Minor	
Address / Phone	
Name	
Relationship to Minor	
Address / Phone	

5. SCOPE AND DURATION OF AUTHORIZATION

Initial:	This authorization is effective for the person(s) named in Section 4 and remains in effect for twelve (12) months from the date signed below, or until revoked in writing by the parent/legal guardian, whichever occurs first. This authorization expires automatically when the patient reaches eighteen (18) years of age.

6. UNACCOMPANIED MINOR PRESENTATION – PARENTAL PRE-AUTHORIZATION (OPTIONAL)

Initial:	IF MINOR CHILD IS 15 OR OLDER: My minor child, named above, may present unaccompanied by an adult and receive routine, non-urgent treatment under this authorization, and may sign for an acknowledgement of my financial responsibility if able to present valid identification. This pre-authorization does not override the treating provider's clinical discretion to defer non-urgent treatment if, in the provider's judgment, the patient cannot meaningfully participate in the informed consent process for a specific procedure.

7. NOTICE OF PRIVACY PRACTICES (HIPAA)

Initial:	I acknowledge I have been offered a copy of Midwest Express Clinic's Notice of Privacy Practices, and I authorize the person(s) named in Section 4 to receive protected health information reasonably necessary to arrange and consent to my child's care, subject to any confidential-services limitations described in Section 1. This authorization does not entitle the person(s) named in Section 4, or the undersigned parent/legal guardian, to receive information about services for which the minor has independently consented under applicable state law, unless the minor authorizes such disclosure.

8. FINANCIAL RESPONSIBILITY

I understand that I remain financially responsible for services provided to my child under this authorization, and that the person(s) named in Section 4 may sign financial responsibility and billing-related forms on my behalf at the time of service. I assume sole responsibility for these determinations and authorize Midwest Express Clinic to bill my insurance carrier and to release information necessary to process claims.

9. SIGNATURES

Parent/Legal Guardian Name		**Signature**	
Date		**Relationship to Minor**	
Witness Name (Clinic Staff)		**Signature**	

10. FOR STAFF USE ONLY

Date Received		**Expiration Date (+12 mo.)**	
Designated Adult ID Type/Last 4		**Verified By (Staff Initials)**	
Legal Guardian Docs Attached?		**Scanned to Chart?** ☐ Yes ☐ No	