Minors Consent to Testing/Release of Information

I give consent to Entira Family Clinics to perform: (please circle those that apply)

Drug Screen **Pregnancy Test** **STD Test**
Behavioral/Mental Health Evaluation **Contraception Counseling**

I understand the results of my test/evaluation will be confidential and may not be released to anyone without my written authorization. Entira Family Clinics will not release any medical information to my parent(s) without my prior authorization.

I understand that if I want my parent's insurance company to pay for the test, Entira Family Clinics cannot guarantee confidentiality because the insurer may release billing information to my parent(s).

Bill my parents insurance (please circle)

I understand I may pay for the test myself (please circle)

Bill my insurance
I will pay cash prior to test

**** If patient prefers to pay cash direct patient to the Account Coordinator to collect payment and assure account is set up properly.**

The following Parent(s) or Guardian(s) may receive the results of my test(s)

Name________________________________Relation_______________________DOB______________

Name________________________________Relation_______________________DOB______________

____
Print Name (First, MI, Last) (patient) DOB

____ ________________________
Signed (patient) Dated

Scan document in Patient Documents: _ _/_ _/_ _ _ _ Minor Consent Form