Three Rivers Family Medicine, PSC

To Parents and Guardians of Minor Children

The providers and staff of Three Rivers Family Medicine, PSC place great emphasis on the health and well being of each and every patient in our clinic and we appreciate that you have entrusted us to provide health care services to your minor child. We look forward to working with you to ensure that your child receives the best Health care possible.

As a general rule, we require the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). With so many parents working outside the home or with other commitments, we realize that you may not be able to accompany your child on every visit to the clinic. If your minor child presents to the clinic unaccompanied or in the company of an adult other than a parent or legal guardian, we will do our best to attempt to contact you for consent. Depending upon the reason for the visit, if we are unable to contact you for consent, we may need to reschedule the appointment.

In an effort to provide the care needed and avoid having to reschedule your child's appointment, we have developed an Advance Consent to Treat Minors form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and emergency medical treatment for your minor child when deemed necessary by qualified medical personnel. This consent form will remain in effect until revoked in writing. You may request this form from any member of our clinic staff.

Under Washington State law, minors have the right to consent to certain health care without a parent or guardian's consent.

A minor may consent to medical care:

- If the minor is emancipated (legally independent) or married to someone at or above age 18.
- In the event emergency care is necessary.
- For birth control and pregnancy-related care at any age.
- For outpatient drug- and alcohol-abuse treatment beginning at age 13.
- For outpatient mental health treatment beginning at age 13.
- For sexually transmitted diseases, including HIV, beginning at age 14.

If a minor consents to care as allowed by law, he or she has confidentiality for that aspect of care which would prohibit us from releasing this information to anyone, including a parent or guardian, without the minor's express written permission.

It is the philosophy of this clinic to encourage minor patients to include a parent, guardian, or other trusted adult in all aspects of their health care including those areas noted above. For legal and other reasons, parent or guardian involvement may not always be possible. Rest assured that we would continue to provide health care services that are in the best interests of your minor child.

If you have questions regarding any of this information, please contact your child's primary care provider.

What to complete:

By Legal Guardian: Advance Consent to Treat Minors Parental Consent

MR Release Form to other places

By Person Receiving Info Kinship Caregivers Informed Consent

TR FM Three Rivers Family Medicine, PSC

Parental Consent

Advance Consent to Treat Minors

I, _____, the parent or legal guardian of _____, authorize and consent to routine & emergency medical treatment for him/her when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

_____

Signature of parent/legal guardian Date

Patient Name:_____

Legal Guardians: _____

_____

945 Goethals Drive, Suite 300 Richland, WA 99352
Phone 509-943-3196 Fax 509-946-0455

ROI – TRFM discuss Care with another party

Three Rivers Family Medicine, PSC

Authorization to Use or Disclose Protected Health Information

Patient name: _____ **Date of birth:** _____

Previous name: _____

I. My Authorization: TRFM, PSC may use or disclose the following health care information

(check all that apply):

- □ All health care information in my medical record
- □ Health care information in my medical record relating to the following treatment or condition:

  _____
- □ Health care information in my medical record for the date(s): _____
- □ Other (e.g., X-rays, bills)—specify date(s): _____

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for

(check all that apply):

- □ HIV/AIDS
- □ Sexually Transmitted Diseases
- □ Mental Health or Illness
- □ Drug and/or Alcohol Abuse
- □ Reproductive Care (minors only)

***Minors** – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 & older), drug &/or alcohol abuse (if age 13 & older), & mental health or illness (if age 13 & older).*

You may disclose this health care information to:

Name (or title) and organization or class of persons: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This authorization ends:

- □ on (date): _____
- □ when the following event occurs: _____
- □ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **TRFM, PSC** in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form—a form is available from **TRFM, PSC** or
   - Write a letter to **TRFM, PSC.**

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date Time

Sept 22, 2013

Three Rivers Family Medicine, PSC
Kinship Caregivers Informed Consent Declaration for Minors

Persons authorized to provide informed consent to health care on behalf of a child under the age of 18 must be a member of one of the following classes of persons in the following order of priority (RCW 7.70.065):

1. A guardian or legal custodian appointed by the court;

2. A person authorized by the court to consent to medical care for a child in out-of-home placement pursuant to the dependency and termination of parental rights statutes;

3. Parents of the minor patient;

4. A person to whom the minor's parent has given a signed authorization to make health care decisions for the minor patient; and

5. A competent adult representing himself or herself to be a relative responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of perjury stating that the adult person is a relative who is responsible for the health care of the minor patient.

The following declaration applies to a person in category 5 listed above:

I _____ am a relative of _____
(print name) (print name of minor patient)

and am responsible for his or her health care. I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed at _____ on _____
(place) (date)

_____
Signature

_____
Relationship to minor patient

This declaration is effective for no more than six (6) months from the date on which it is signed.