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CONSENT FOR TREATMENT OF A MINOR

CONSENT BY PARENT/LEGAL GUARDIAN

I, the undersigned, as the parent or legal guardian of _____ (the “minor”), have the legal authority to give consent for the treatment of this minor.

I hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate, including but not limited to a pelvic exam. I agree that treatment may be provided in my absence. This consent shall remain in effect unless revoked in writing.

Minor’s Name _____ DOB _____

Relationship _____

Signature of Parent or Legal Guardian _____
Date: _____

According to Florida law, a parent or legal guardian must consent to the treatment of a minor (any person under 18 years of age) except under certain exceptions*.

*The exceptions are listed below:

The minor is:

1. An emancipated minor (emancipated by court (must provide court order), or does not reside with their parents and the minor is financially independent (§743.015(6), Florida Statutes).
1. Married, divorced or widowed - must provide copy of court document (§743.01, Florida Statutes).
2. A mother (who is a minor) may provide consent to treatment of their child (ex: Minor consenting to her child’s circumcision) (§743.065(2), Florida Statutes.)
3. Pregnant and consenting to treatment of my pregnancy (§743.065(1), Florida Statutes).
4. Consenting to treatment of sexually transmitted diseases. (§384.30 (1) and (2), Florida Statutes).
5. Consenting to treatment related to family planning (ex. birth control and/or pregnancy) (§381.0051 (4)(a)(1-5) and (b), Florida Statutes).

**In circumstances when the minor has the legal right to consent, Florida law prohibits the release of the minor’s medical records for such treatment without the minor’s written consent.

Name: _____ DOB: _____ Date: _____