South Lake Pediatrics
Minors (13-17)
Consent for Services/Release of Information

Consent to Treat

Minnesota law requires South Lake Pediatrics to obtain consent from a parent or legal guardian for medical services provided to patients under 18 years of age, except for treatment for which a minor may provide valid consent under Minnesota law. Parental consent is not required for the services listed on this form. By signing below, I consent to South Lake Pediatrics performing the following types of services while I am a patient: (please check those that apply):

- ☐ **Contraception Counseling**
- ☐ **Pregnancy Testing or Treatment**
- ☐ **STD Test**
- ☐ **Substance Use Disorder Evaluation and Treatment**

I understand my care as it relates to the above categories of services will be confidential and will not be released to anyone except to those individuals authorized on this form or as otherwise permitted or authorized by law. South Lake Pediatrics will not release any medical information to my parent(s) without my prior consent, unless my provider deems that withholding information from my parent(s) would pose a serious health risk to me, in accordance with Minnesota Statutes Section 144.346.

Billing Options

Please check one box below:
□ Bill my parents' or guardians' insurance
□ Bill my insurance (I pay for my own insurance separate from my parents)
□ I will pay cash

I understand that if I want my parent's insurance company to pay for these services, South Lake Pediatrics cannot guarantee confidentiality because the insurer may release billing information to my parent(s) or legal guardian. I further understand that I may choose to pay for the test/evaluation myself to avoid such disclosures.

Release of Information

I consent to the disclosure of health information pertaining to services circled on this form, including any test results and information pertaining to my treatment, to the following Parent(s) or Guardian(s):

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand that the consent to disclose information pursuant to this form will allow South Lake Pediatrics, including its providers and staff, to discuss my care with the above individuals both verbally and in writing. This consent lasts until I turn 18 unless I request to withdraw this consent by emailing healthinformation@slpeds.com. I understand that by signing this form all prior authorizations to release health information will no longer apply, as of the date of this form, with respect to disclosures regarding the treatment categories noted on this form.

_____
Print Patient Name (First, MI, Last) DOB

_____ Okay to leave voicemail on this number? □ Yes □ No
Patient Cell Phone Number

_____ _____
Patient Signature Date

11/2022