



CONSENT FOR MEDICAL CARE FOR A MINOR PATIENT

I hereby consent to medical treatment for my minor child:

_____ DOB: _____,
by Queen City Women's Health.

Details of Consent:

- 1. Purpose:** The purpose of this consent is to protect the rights of the minor patient and that of their legal guardian as it relates to their medical care at Queen City Women's Health. This care may include but not limited to: treatment for sexually transmitted illness, pregnancy, birth control or care related directly to women's health.
- 2. Confidentiality:** I understand that all information collected during the course of my child's medical care at Queen City Women's Health will be kept confidential to the extent allowed by law.
- 3. Withdrawal:** I understand that I may withdraw my consent and discontinue participation of medical treatment at any time without penalty or loss of benefits to which my child is otherwise entitled.
- 4. Contact Information:** If I have any questions about my rights as a parent, or if I wish to lodge a complaint or provide feedback regarding the medical care provided to my child, I can contact the Practice Administrator of Queen City Women's Health.
- 5. Consent Duration:** This consent shall remain in effect until revocation by parent or legal guardian, until the patient becomes an adult (age 18 or older) or the patient becomes an emancipated minor.

I acknowledge that I have read this consent form or have had it read to me, and I understand its contents. By signing below, I voluntarily agree to allow my child to receive care at Queen City Women's Health.

Parent/Legal Guardian Signature: _____

Date: _____

Witness (if applicable): _____

Date: _____

Note: This consent may be modified to comply with specific requirements of House Bill 2936 in Tennessee, or any other applicable laws and regulations, and as such may need to be amended and a new consent signed.