PEDIATRICS SOUTH

OFFICE USE ONLY

Patient Number: ______________________

Date of Birth: ________________________

Date Notice Received: _________________

Adolescent Medical Release and Consent Agreement Form

Name: ____Date of Birth:________________

Patients Phone Number: _________________________________

I give my permission to **Pediatrics South** to discuss the following information about my health with these individuals (please list names below):

Related to my Mental Health:____

Related to Drugs and Alcohol:____

Related to my Sexual Health:____

Birth Control:____

Sexually Transmitted Infections: ____

Pregnancy: ____

Sexual Orientation: ____

All of the Above: ____

Signature: ____

Date: ____

*Patients ages 14-17 are legally allowed to seek and receive medical care for issues related to their sexuality, mental health, and drug or alcohol use/abuse without the knowledge or consent of their parents. The only exceptions to these rules are if there are concerns about child abuse, or if the patient has plans to hurt himself/herself or someone else. In those circumstances, we are required to report the concerns to the appropriate authorities.