

San Antonio Clinic

Student Consent Form

Under California law, youth do not need parental consent to receive certain health care services, often called “minor consent” services. Some examples of “minor consent” services that youth may obtain on their own, if they meet the legal requirements, include mental health counseling; alcohol and drug abuse counseling; diagnosis, treatment and preventative care for sexually transmitted diseases; and care related to pregnancy and pregnancy prevention. Youth also may be able to consent to their own healthcare because of their status or living situation. If you would like more information about whether you qualify for this care and the services we provide, please talk to us. If you are interested in consenting to your own care, please read this form carefully and complete.

**Name of Student:** \_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s School ID#: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Grade:** \_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City: \_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_

**Birth Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Contact? □ Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **□ Cell Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is important to know that we may need to contact you prior, during, and/or after your care. The number identified above is the method we will use to reach you.

I am able to consent to my own care because:

**□** I am 18 years old or older

**□** I am or have been married, in the armed forces, or have been emancipated by a court.

**□** I am 15 years old or older, living separate and apart from my parents, and managing my own financial affairs

**□** I am seeking “minor consent” services.

5. I understand my consent covers only those services provided at San Antonio Clinic. I understand that I can change my mind later on and decide I do not want health or mental health services. If I change my mind, I will let San Antonio Clinic know in writing.

6. I understand that San Antonio Clinic is *required* to keep my health information protected but that in some cases, they may need or be required to share it by law. I understand that I can ask for more information about confidentiality.

7. I understand that Petaluma Health Center needs to cover its expenses and may bill third parties for these services, including any applicable health insurer, or ask meto enroll in Medi-Cal or another public insurance program, or may bill me for services based on sliding fees that are determined based on my income and family size.

Signature of Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_