Lakeside Pediatric & Adolescent Medicine, PLLC

AUTHORIZATION FOR TREATMENT OF MY MINOR CHILD

Patient Name: _____ DOB: _____ Age: _____
(Last) (First) (Middle)

Authority: I am the parent, guardian, or other person legally authorized by Idaho law to consent to health care services for the Minor Patient pursuant to Idaho Code § 32-1015.

Consent for Treatment: I voluntarily consent to and authorize Lakeside Pediatrics and Adolescent Medicine, PLLC and its employed or affiliated physicians, practitioners, and staff to render the following health care services to the Minor Patient named above.

- **General Consent**: Medical evaluation, diagnosis, and treatment; diagnostic services including lab tests or radiology procedures; prescription and administration of medications; counseling; and any other health care services as defined in I.C. § 32-1015 deemed reasonably necessary and appropriate by the treating Provider. This consent shall constitute a "blanket consent" within the meaning of I.C. § 32-1015(4)(a) and no further consent is required to authorize such health care services.

Acknowledgments

_____ (*Parent Initials*) If I have questions regarding any health care services consented to under this form, I will contact Lakeside Pediatrics and Adolescent Medicine, PLLC to address the questions. I understand that the practice of medicine is not an exact science and no promises or guarantees have been made nor can they be made to me concerning the outcome of the health care services. I understand if I have any questions regarding this authorization or about the services offered that I may discuss them with my child's healthcare provider.

By signing below, I acknowledge I have read, and I understand the above. I declare that I am the minor child's biological parent, adoptive parent, or the individual granted exclusive right and authority over the welfare of a minor child under state law. I understand that I may revoke this consent at any time. Except to the extent that services have already been rendered. To revoke this authorization, I further understand that I must provide written notice to Lakeside Pediatric and Adolescent Medicine, PLLC. There are no penalties for revoking consent.

_____

Parent's Full Legal Name (please print) Signature Effective Date

OPTIONAL SECTION BELOW

Authorization for Minor Child to Schedule and Attend Appointments Alone

_____ (Parent Initials) I authorize Lakeside Pediatrics and Adolescent Medicine, PLLC to allow my minor child (14 yrs. and older) to receive medical evaluation, diagnosis, and treatment; diagnostic services including lab tests or radiology procedures; prescription and administration of medications; counseling; and any other health care services as defined in I.C. § 32-1015 deemed reasonably necessary and appropriate by the treating Provider with or without my knowledge or presence. This consent shall constitute a "blanket consent" within the meaning of I.C. § 32-1015(4)(a) and no further consent is required to authorize such health care services.

OPT-OUT: By initialing a line item below, I am specifically excluding the identified health care services indicating **I DO NOT** provide General Consent for the identified health care services without a legal guardian present unless otherwise later agreed:

_____Contraceptive care services, including prescribing birth control, treatment of menstrual irregularities, and other similar care.

_____Discussions around gender identity.

_____Discussions around sexual orientation.

_____Immunizations/Vaccinations without the presence of parent or guardian.

_____Mental and Behavioral Health Services, including treatment for depression, anxiety, counseling, and other similar services.

_____Testing for and treatment of sexually transmitted infections, including such testing and treatment for gonorrhea, chlamydia, herpes, and other similar infection

Authorization of Other Caregivers

I, _____, hereby consent to Lakeside Pediatric and Adolescent Medicine, PLLC allowing the below caregiver(s) to make appointments for my child and bring my child to appointments for the health care services authorized above.

Caregiver's Name	Relationship to Child	Phone Number

_____

Parent's Full Legal Name (please print) Signature Effective Date

This form will expire one year from the Effective Date.