



MICHELE M. THOMPSON, M.D.
DERMATOLOGY

CONSENT TO TREAT MINOR

PATIENT'S NAME: _____ DATE OF BIRTH: _____

This consent form allows the staff and providers of Michele M Thompson MD LLC to provide routine and emergency medical treatment when deemed necessary by qualified medical personnel.

Under Washington state law, minors have the right to consent to certain medical services without a parent or legal guardian's consent. Minors may consent to medical care:

- In the event emergency care is necessary.
- For birth control and pregnancy-related care at any age.
- For outpatient drug and alcohol abuse related treatment beginning at age 13.
- For outpatient mental health treatment beginning at age 13.
- For sexually transmitted diseases, including HIV, beginning at age 14.
- If the minor is emancipated or married to someone 18 years of age or older.

If a minor consents to medical treatment or care as allowed by law, he or she can request confidentiality for that aspect of care which would prohibit us from releasing this information to anyone, including a parent or legal guardian, without the minor's written permission.

If a minor child arrives to the clinic unaccompanied, or in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. **If the minor does not have consent for the treatment the appointment will be rescheduled.**

I, _____, the parent or legal guardian of
_____, hereby authorize Michele M Thompson MD LLC to
provide routine and/or emergency medical treatment and procedures when deemed necessary by
qualified medical personnel.

This authorization shall continue to be in full effect until revoked in writing by me.

Signature

Relationship to Patient

Date