Meridian
FAMILY MEDICINE

As of July 01, 2024 – In compliance with Idaho Code § 32-1015, Meridian Family Medicine requires parental consent to furnish all health care services to a minor patient, unless prohibited by court order or law. This form must be completed and signed by a parent of the minor child (under 18 years old), unless the minor is emancipated. "Parent" means the biological or adoptive parent of the minor or an individual who has been granted the exclusive right and authority over the welfare of the minor under state law.

BLANKET CONSENT FOR HEALTH CARE SERVICES OF A MINOR CHILD

Patient Name: _____ **Date of Birth:** _____

I voluntarily consent to and authorize Meridian Family Medicine and its physicians, practitioners, and staff to render health care services to my child as may be deemed necessary or advisable by the treating provider or staff. I understand that this blanket consent for health care services allows for the diagnosis, screening, examination, prevention, treatment, cure, care, and relief of my child for any physical or mental condition, illness, injury, defect, or disease, including, but not limited to:

- Medical Evaluation, Diagnosis, & Treatment
- Lab & Radiology Services
- Prescriptions & Medication Administration
- Immunizations & Vaccinations
- Substance Abuse Screening & Treatment
- Behavioral or Mental Health Screening & Treatment
- Reproductive Health Care & Contraception *(including birth control)*
- HIV Testing & Treatment
- Sexually Transmitted Disease or Infection Testing & Treatment
- Other health care services deemed reasonably necessary & appropriate as defined in I.C. §32-1015

☐ In the event that the parent is unable to accompany the minor patient to appointments, the below individual(s) are authorized to accompany the minor patient to their appointment and consent to the above services provided by Meridian Family Medicine:

Adult Individual's Name: _____ Relationship to Patient: _____

Adult Individual's Name: _____ Relationship to Patient: _____

☐ My child is 16 years of age or older and is authorized to attend appointments unaccompanied by a parent or authorized individual. I consent Meridian Family Medicine to render the above health care services and treatment to my child without the presence of a parent or authorized individual. ***Note: All appointments for refills of ADHD/controlled substance medications will require a parent/guardian present. This authorization may not be applicable for all appointments as deemed appropriate by the treating provider.***

Acknowledgement I am the parent, guardian, or other person legally authorized by Idaho law to consent for health care services for the minor patient pursuant to Idaho Code § 32-1015. By signing this form, I acknowledge that I have read and understand my rights and the purpose of providing parental consent for today and all future visits and/or treatment of my child. I understand that I have a right to be informed and ask questions about my child's condition and the recommended treatment or procedure to be used so that I may make the decision whether or not my child should undergo any suggested treatment or procedure knowing the risks and benefits involved. I understand this may exclude emergency situations when furnishing health care service(s) is necessary to prevent death or imminent, or irreparable physical injury to the minor child. I understand that no substantial procedure will be performed without being provided with an opportunity to give or refuse informed consent for that specific procedure. I understand that I have the right to I agree to have my child speak with a provider alone for services as outlined above if they choose to do so.

Financial I agree that I am ultimately responsible for payment for the health care services rendered to the Minor Patient and agree to comply with Meridian Family Medicine's Financial Policies including paying for interest and fees charged for a delinquent account. I am aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

Consent Duration/Revocation I understand that I may revoke this consent at any time by providing written notice to Meridian Family Medicine. However, I acknowledge that revocation of consent may not be effective in emergency situations where my child's life or health is at risk and does not apply to any uses or disclosures made by Meridian Family Medicine before receipt of this completed revocation form or for uses or disclosures that are allowed or required by law. Unless revoked earlier, I understand that this blanket consent will be valid for a period of one (1) year from the date of my signature below

Parent Signature	Parent Name (Printed)	Date