

UT Family Medicine
Policy for Treatment of Minors

If you are the parent or legal guardian of a child under the age of 18, please read this policy carefully. If you are the legal guardian and not the parent, you will need to supply a copy of the court order granting you guardianship.

If your minor child is being brought to the office by someone other than a parent or legal guardian, or if your child is of driving age, under the age of 18, and coming to the office by his/her self for medical treatment, they will need to provide a written release signed by a parent or legal guardian before we can treat the child.

The written release must contain the following:

- Statement giving us permission to treat your minor child for a specific condition
- Name and date of birth of the minor child
- Phone number where we can reach the parent or guardian should an emergency arise or medical personnel need to speak with the parent or guardian
- If the minor is being brought in by another individual, you must include the name and relationship of the individual with a statement that they may authorize treatment of your minor child
- Pharmacy name and number should a medication need to be prescribed

Your child, or the person bringing your child, must have a current insurance card or copy of front and back of the card with the policy holders name and date of birth written on the copy.

You may give us permission for specific individuals to authorize treatment of your minor child by providing a signed written release. On this authorization you must include the name and date of birth of the child as well as the names of the individual(s) you allow to authorize medical treatment.

The only exceptions to the above policy regard reproductive health. The State of TN allows minors to consent to testing and treatment of sexually transmitted diseases (STDs) without notifying the parent/guardian. Pregnant minors are also exempt from the policy when their visit is related to the pregnancy.

Parent or Legal Guardian ONLY _____ (indicate with check mark)

In addition to the mother, father or legal guardian, the following individuals may accompany and authorize treatment for my minor child, including immunizations, office procedures, and other medical therapy:

1) _____, 2) _____, 3) _____

I understand I have the right to revoke this authorization in writing at any time.

Patient Name (please print)

Date of Birth

Patient Address

Signature of Patient/Guardian

Date of Authorization

Failure to provide this information may result in a delay of your child being treated until we are able to obtain this information.

If a minor child is being brought by someone than a parent and/or guardian, please list the name and relationship below:

Please list the phone number where the parent and/or guardian can be reached if medical personnel need to speak with parent and/or guardian. _____

