Gilman, Curalli & Gilman DO PS
1414 N Vercler Rd Bldg 4, Spokane Valley, WA 99216
509 924-4681

PRIVACY CONSENT for MINORS   TODAY'S DATE____________

PATIENT NAME ________________DATE OF BIRTH ___________   PATIENT AGE _____

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about the above named patient**.** You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you will receive our revised copy.

You have the right to request that we restrict how Protected Health Information about the above named patient is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you consent to our use and disclosure of Protected Health Information about the above named patient for treatment, payment and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent.

You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you will receive our revised copy. By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on our prior consent.

I_______________________, give Drs. David Gilman, Nick Curalli, Bryce Gilman and Staff permission to use and disclose Protected Health Information related to the minor ________________for treatment, payment and health care operations.

Parent/Guardian Signature______________________________Date_______________

ADVANCED CONSENT TO TREAT MINORS

I, ____________________, the parent or legal guardian of my child**, ________________,** authorize and consent to routine and emergency medical treatment for _________________ when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me or when _______________ no longer requires my consent for treatment.

Parent/Guardian Signature______________________________Date_______________

If you want us to leave a phone message regarding the patient's Protected Health Information, please supply the phone number __________________________.

(Supply a phone number ONLY if you are giving us your authorization to leave a message regarding PHI)

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In Washington State, Minors are persons less than 18 years of age. Minors cannot consent for their own medical care with exception to the following:

- Sexually Transmitted Disease/HIV Testing (RCW 70.24.110) Minors age 14 and older may seek care for STD's; diagnostic and treatment information in confidential in this instance.
- Alcohol and Drug Treatment Outpatient and inpatient treatment of minors for chemical dependency (RWC 70.96A.095 and RCW 70.96A.097) Minors age 14 and older may give consent for himself or herself to the furnishing of outpatient treatment by a chemical dependency treatment program certified by the department. Parental authorization is required for any treatment of a minor under age 13.
- Mental Health Treatment Outpatient and Inpatient (RCW 71.34.530 and RCW 71.34.500) A minor 13 or older may be admitted for either inpatient or outpatient mental treatment without parental consent.
- Abortions/ Contraception Law provides for a minor's ability to provide consent for abortion, birth control and reproduction. There is no age limit. (See Stat v. Koome)
- Marital Status The marital status of a minor impacts the minor's ability to consent for treatment. "all minor persons married to a person of full age shall be deemed and taken to be of full age."