Lincoln OB GYN P.C.

9110 Andermatt Drive, Suite 2
Lincoln, NE 68526-9639
Telephone (402) 483-7641
Fax (402) 483-0527

Authorization to Consent to Medical Services for a Minor Child

I _____, certify that I am the parent or legal guardian of _____
(Parent or Legal Guardian)

_____, date of birth: _____, a minor and that I am authorized to provide informed consent for any medical treatment for said minor child as follows:

Initial and Select option 1, 2 or 3 (select only one)

1. _____ **I hereby give Lincoln OB GYN P.C. consent to provide all medical services required for, or requested by the minor child and no further consent from me will be required to provide medical services at any time after the date of this document.**

2. _____ **I hereby give Lincoln OB GYN, P.C. consent to provide the following medical services required for or requested by the minor child as reflected by my initials and no further consent from me will be required to provide such medical services at any time after the date of this document:**

_____Office Visits, including pelvic exam

_____Pap Smear

_____Laboratory Tests, including blood tests or cultures

_____Office Procedures, including Colposcopy, Cryotherapy, Ultrasound

_____Prescriptions/Injections including birth control, antibiotics etc.

_____Obstetrical Services

3. _____ **Any medical services provided to the minor child shall require my consent at the time such services are provided.**

I understand I am financially responsible for any medical services provided by Lincoln OB GYN, P.C. to the minor child. I further understand that my consent to treat will remain in effect until the minor child reaches the age of majority (19) or I provide written notice to the Clinic that I am revoking my consent.

Printed name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____ Date: _____

***** If you are the legal guardian, you must provide the office with Letters of Guardianship*****