Tapestry 360 Health
Minor Consent

Name:_____ Sex: M F Birthdate: _____
Last First

Address:_____ Zip:_____ Telephone: ( ) _____-_____

Race: American Indian/Alaskan Native, Black Hispanic/Latino, Black Non-Hispanic/Latino, Mixed Race, White Hispanic/Latino, White Non-Hispanic/Latino, Asian

Preferred Language: English Spanish Other (specify) _____

Do you have health insurance? (circle one) Yes No Unsure

If you do, please circle one of the following: All Kids Medicaid HMO PPO

MINOR CONSENT FOR HEALTH CARE AND CONFIDENTIALITY POLICY

I agree to receive health services at Tapestry 360 Health. According to Illinois law, Persons from 12 to 18 years of age can consent to receive certain health services including: birth control, pregnancy testing, STI testing and treatment, HIV testing, pregnancy related care, and counseling.

As I am under the age of 18 years and not legally independent from my parents, I understand that this consent applies only to the services listed above. I also understand that I may withdraw my permission at any time.

As a patient of Tapestry 360 Health, information about me will not be released to anyone outside of Tapestry 360 Health without my permission. This means that they will not talk about me to my parents, teachers, police, or anyone else, unless I say that it is OK.

The following are a few exceptions. They may have to tell someone if:
1) An injury or accident happens on school property.
2) I tell them that I am being physically or sexually abused.
3) I have done harm or could do harm to myself or someone else.

I understand that Tapestry 360 Health may not inform my parent or guardian of the fact that I am receiving these services without my consent. Should the staff determine to notify my parent or guardian for reasons of safety, **I understand that the staff member will make every attempt to notify me first.**

Just as the Tapestry 360 Health staff agrees to protect my confidentiality, I agree to respect the confidentiality of all other patients that I may see at Tapestry 360 Health. This means that if I see another student/patient in the health center and/or I hear information about someone that may be personal, I agree to keep that information to myself and tell no one else.

Signed_____ Date_____

Witness_____ Date_____