The Center
for Youth Health & Wellness

Address: 2001 N. Lincoln Road

Escanaba, MI 48929

Office Hours: M 8am-5pm, T 10am-7pm,

W+TH 8am-5pm, F 8am-12pm

Phone # (906) 786-1672

Fax # (906) 786-6762

MINOR CONFIDENTIAL SERVICES CONSENT

Student Name (Last, First, MI)	Birth Date	Age	Sex	Grade
Address	City	Zip Code	Student Phone	

Race/Ethnicity: ☐ African American ☐White ☐ Hispanic/Latino ☐ Native American Indian/Alaskan ☐ Asian ☐ Native Hawaiian/Pacific Islander

Parent/Guardian Name (Last, First, MI)			Relationship to Student
Home Phone #	Work Phone #	Cell Phone #	Parent Email Address
Emergency Contact	Relationship		Telephone #

Confidential Services:

Under Michigan Law, I understand that minors may without parental consent, receive advice, testing and/or treatment for substance abuse, reproductive health services (not including abortion counseling or referrals), sexually transmitted diseases, HIV, and mental health services, which are defined as Confidential Services.

I further understand that minors above the age of 14 years can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications.

I understand that the provider treating me may notify my parent or guardian without my permission if someone is hurting me or I am hurting myself or someone else, or if I have a plan to hurt myself or someone else, or it is seen to be in my best interest. In those cases, the provider will try to inform me of their duty to notify my parents before informing them.

If I am seeking information or intervention about one of the confidential services, I understand that I can seek care related to these issues at the Center for Youth Health & Wellness. I also have the right to refuse or defer treatment.

I have read and understand the above information and sign it freely and voluntarily.

By signing this form, I agree to the following:
- I have reviewed and understand the Confidential Services offered by the health center. I give my consent to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I further authorize the Child and Adolescent Health Center to release information regarding treatment to the following: Health Center staff, its subcontractors, and other health care providers when needed to coordinate care and school staff when needed to coordinate services. I understand I may withdraw my consent for services at any time upon written notice.
- I received a copy of the Health Department's Notice of Privacy Practices brochure.
- I have completed the enclosed Student and Family Health History form on the back side of this form.
- I understand there will be no charge or billing for this service

Date

Printed Name and Birth Date

Signature

Witness Signature