Minor Authorization to Share "Special Consent Area" Treatment Information (Ages 12-17 only)

Trinity Health

IHA Medical Group

Under Michigan confidentiality and minor consent laws:

- A parent or legal guardian must provide consent on behalf of a minor (anyone under age 18) before health care services are provided

However, there are a few important exceptions:

- Emergency care
- Care for emancipated minors
- *Specific and limited health care services related to sexual health, mental health, and substance use treatment (known as "special consent areas")*

WHAT ARE SPECIAL CONSENT AREAS?

1. Patients ages 12-17 have the right to the following ***WITHOUT*** parental/guardian consent or knowledge:
   - Pregnancy testing and prenatal care
   - Birth control information and contraceptives
   - Testing and treatment for sexually transmitted infections (STIs), including HIV
   - Substance use disorder treatment
2. Patients ages 14-17 can access outpatient mental health counseling ***WITHOUT*** parental/guardian consent or knowledge for up to 12 visits or 4 months

Healthcare providers **must** override the minor's confidentiality and report if there is suspicion of abuse by an adult, the minor is a risk to themselves or someone else, or the minor is under age 12 and has been sexually active. The provider may choose (but is not obligated) to tell the parents about any care provided to the minor patient for a compelling medical reason.

As a teen, it is your choice if you want to sign this form.

- ***Signing this form ALLOWS sharing only the areas noted below with your parent/guardian. If you do not want to share anything, you do not need to sign any forms.***
  You may change your decision at any time by completing a new form.

☐ Pregnancy testing and prenatal care
☐ Birth control information and contraceptives
☐ Testing and treatment for sexually transmitted infections (STI's) which includes HIV
☐ Substance use disorder treatment
☐ Outpatient mental health counseling only (14 -17 years)

I would like to CHANGE my decision on a previous form:

☐ I want to change my decision and I DO NOT WANT TO SHARE information on the previous minor authorization "special consent area" treatment information form

I want to share with this Parent/Guardian: Name: _____Relationship: _____

I want to share with this Parent/Guardian: Name: _____Relationship: _____

PRINT Patient First and Last Name | Date of Birth | Teen Cell Phone Number

SIGN Patient's Name | Today's Date

Form updated 11.10.22