KODIAK AREA NATIVE ASSOCIATION

# HEALTH SERVICES

## MINOR CONSENT TO TREATMENT

Minor Patient Name: _____ Date of Birth: _____

Name(s) of all parents or legal guardians: _____

I understand that under Alaska law, AS 25.20.025, I am allowed to seek medical or dental services for myself in certain circumstances listed below, without notifying or requesting permission from my parent(s) or legal guardian(s), and that I must check the box that applies to me.

- ☐ I am living apart from my parent(s) or legal guardian(s) and am managing my own financial affairs (regardless of the source or extent of my income).
- ☐ My parent(s) or legal guardian(s) cannot be contacted or, if contacted, are unwilling either to grant or withhold consent to my medical care. Reason they cannot be contacted:
  _____
  _____
  _____
- ☐ I am seeking care for diagnosis, treatment or prevention of pregnancy.
- ☐ I am seeking diagnosis, treatment or care for a sexually transmitted infection/disease (STI or STD).
- ☐ I am the parent of a child and am seeking medical and dental services for myself or for my child.

I also understand my health records are confidential and protected by certain privacy laws, and that my parent(s) or legal guardian(s) do not have the right to know or access the health records for services that I consented to on my own behalf, unless KANA determines that an imminent threat to my health or safety necessitates disclosure to my parent(s) or legal guardian(s).

By signing this consent form, I acknowledge that I am financially responsible to pay for the services that I receive from KANA, if not otherwise covered by KANA, and not my parent(s) or guardian(s). I understand that if I offer my parents' insurance to pay for services, KANA cannot guarantee non-disclosure of my health information to my parents. I also understand that I may consult with KANA to ask about what resources are available to me to pay for my financial obligations, but that KANA cannot guarantee that such resources will be available.

**Signature of Minor Patient: _____ Date: _____**

***For KANA's Use Only:***

Intake By: _____ MRN: _____ Date: _____