Genis Women Care, PC
2790 Godwin Blvd. #375
Suffolk, VA 23434
(757) 923-4500 Phone
(757) 923-4607 Fax

Consent of a Patient to Release Medical Information to a Parent, Guardian or Other:

Patient Name:_____ Date of Birth:____/____/_____
I hereby authorize Genis Women's Care, PC to release my medical information to my parent/legal guardian or Other listed:

Parent/Legal Guardian or Other:_____
Address: _____
City, State & Zip:_____
Phone: (_____)_____

List Any Others With Permission:_____

I understand that under Virginia Law, as a "Minor", I am deemed an adult and can consent to my own treatment without the consent of notification of parent or legal guardian for the purpose of:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease which the State Board of Health requires to be reported;
2. Medical or health services required in case of birth control, pregnancy or family planning except for the purpose of sexual sterilization;
3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse;
4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance.

Not withstanding my ability to consent to my own treatment for the above purposes, I want my parent/legal guardian or Other named above to have access to my medical information and be consulted regarding my treatment. This authorization includes full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for future dates of hospitalizations and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric condition and /or sexually transmitted disease unless I specifically indicate its exclusion below.

Exclusions:_____
____
_____

Patient Signature:_____Date:____/____/_____