Women's Clinic of Lincoln, PC
220 Lyncrest Drive
Lincoln, NE 68510

AUTHORIZATION TO CONSENT TO MEDICAL SERVICES FOR MINOR CHILD

I, _____, certify that I am the parent or legal guardian of _____, date of birth _____, a minor, and that I am authorized to provide informed consent for any medical treatment provided to my minor child by Women's Clinic of Lincoln, P.C. ("Clinic"). I hereby choose to exercise my right to consent to medical treatment for said minor child as follows:

_____ (Initial) I hereby consent to the Clinic providing all medical services required for, or requested by, the minor child and no further consent from me will be required to provide such medical services at any time after the date of this document.

_____ (Initial) I hereby consent to the Clinic providing the following medical services required for, or requested by, the minor child as reflected by my initials and no further consent from me will be required to provide such medical services at any time after the date of this document:

_____ Office Visits, including pelvic exam
_____ Pap Smear
_____ Laboratory Tests, including blood tests, cultures
_____ Office Procedures, including colposcopy, Leep, Cryo, etc.
_____ Prescriptions, including birth control, antibiotics
_____ Obstetrical Services
_____ Radiology Services, including ultrasound
_____ Injections, including Gardasil, birth control, hormone therapy
_____ Other _____

_____ (Initial) Any medical services provided to the minor child shall require my consent at the time such medical services are provided.

I acknowledge that I am financially responsible for any medical services provided by the Clinic to the minor child. I understand the nature of the medical services which I have consented to above and I acknowledge that no guarantees have been made to me or my child as to the results thereof. I further understand that the instructions set forth above will remain in effect until the minor child reaches the age of majority or I provide written notice to the Clinic that I am revoking the instructions provided for in this document.

Date _____

This document must be signed in front of an authorized Clinic staff member or a notary public.

_____ Clinic Witness

_____ Signature of Parent or Legal Guardian*

STATE OF _____)
) ss.
COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, _____, by _____.

_____ Notary Public

* If the legal guardian, you must also provide the office with Letters of Guardianship.