

Minor Consent & Confidentiality Fact Sheet

Under Ohio law, upon the request of a minor 14 years of age or older, a mental health professional may provide outpatient mental health services, excluding the use of medication, without the consent or knowledge of the minor's parent(s) or legal guardian. The minor's parent(s) or legal guardian shall not be informed of the services without the minor's consent unless the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of the mental health professional's intent to inform the minor's parent(s), or legal guardian. Services provided to a minor pursuant to this section shall be limited to not more than six (6) sessions or thirty (30) days of services whichever occurs sooner. After the sixth session or thirty (30) days of services the mental health professional shall terminate the services or, with the consent of the minor, notify the parent(s), or legal guardian, to obtain consent to provide further outpatient services.¹

Ohio law requires a minor patient's parent(s) or legal guardian to consent to the prescription of any medication to the minor.

Mindpath Health requires the following with respect to treatment of minor patients in Ohio:

- For minor patients under age 14:
 - The minor patient's parent(s) or legal guardian must sign the Consent to Treatment on the minor patient's behalf
 - The minor patient's parent(s) or legal guardian must sign the Consent to Medications forms in order for the minor to be prescribed any medications
- For minor patients ages 14-17:
 - The minor patient must sign the Consent to Treatment form and Mindpath Health strongly encourages the minor patient's parent(s) or legal guardian to also sign the Consent to Treatment form, although not required by law
 - If only the minor patient's consent is obtained, services shall be limited to no more than six (6) sessions or thirty (30) days of services, whichever occurs sooner, at which point, the minor patient's parent(s) or legal guardian must consent to further services or services will terminate.
 - The minor patient's parent(s) or legal guardian must sign the Consent to Medications form in order for the minor to be prescribed any medications
 - In order to discuss the minor patient's treatment with and disclose the minor's medical information to their parent(s) or legal guardian, the minor must sign the Authorization for Use or Disclosure of Health Information form specifically authorizing disclosure to the minor's parent(s) or legal guardian

In general, Mindpath Health providers will make reasonable efforts, as appropriate consistent with Ohio law, to involve the minor patient's parent(s) or legal guardian in their treatment, which may include the parent(s) or legal guardian's participation in treatment sessions.

¹ Ohio Rev. Code § 5122.04.



Consent to Treatment

I am voluntarily seeking psychiatry services, including medication management and/or psychotherapy, from Mindpath Health for the purpose of diagnosis and treatment, and I hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that Mindpath Health's providers include psychiatrists, psychiatric mental health nurse practitioners, physician assistants, psychologists, counselors, social workers, and marriage and family therapists. I understand that there are both risks and benefits to psychiatric treatment. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

I understand that if the patient is a minor under the age of 18 and I am consenting to treatment on the minor's behalf, I must indicate my authority and sign below. I also understand that if I share legal custody of the minor patient, by signing this consent form I am representing that all parties who have legal custody of the minor have been made aware of, and consent to the minor's treatment.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to withdraw my **Consent to Treatment** at any time.

Patient Signature

Date

Patient Name

Patient Date of Birth

If you are signing this **Consent to Treatment** as a parent, legal guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- | | | |
|---|--|--|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Conservator | <input type="checkbox"/> Power of Attorney for Health Care |
| <input type="checkbox"/> Legal guardian | <input type="checkbox"/> Health Care Surrogate | <input type="checkbox"/> Executor / Administrator |

Signature

Date

Name

