Minor Consent & Confidentiality Fact Sheet

Under South Carolina law, a minor 16-17 years of age may alone consent to treatment, including the prescription of medication.[1]

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

- For minor patients under age 16:
  - 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 16-17:
  - The minor patient must sign the Consent to Treatment and Consent to Medications forms and Mindpath Health strongly encourages the minor patient's parent(s) or legal guardian to also sign these consents, although not required by law
  - 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 South Carolina 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] S.C. Code § 63-5-340.

MINDPATH HEALTH

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.

- ❑ Parent
- ❑ Legal guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

_____ _____

Signature Date

_____

Name