INDIANAPOLIS
CAMPUS HEALTH

Parental Authorization and Minor Consent Form

This form is signed by the parent or guardian of the named individual who has not yet attained the legal age of 18 (who is not emancipated).

Minor's Name	Birthdate (month/day/year)

I agree for the above listed child to receive health care services such as medical, nursing and/or other health care, which may include procedures, tests, drugs, and treatment necessary to the child's care. I understand that IU Indianapolis Campus Health (CH) provides a continuum of care and therefore may contact other healthcare providers and services with the minimum necessary information to facilitate the child's ongoing care. I understand that the child may receive care through telehealth services. The limitations of telehealth visits include the possibility of not being able to detect conditions found during a complete provider exam. There may also be technical difficulties like a lost connection or interruption. I know that my signature provides consent for IU Indianapolis CH to share this information as needed and provides permission for these services to contact the child once the provider writes an order. I know that I have a right to consent to or refuse to consent to any future care for the child and to discuss this care. The health care provider will discuss with the child either in person or on-line, specific care and/or interventions including procedures, and obtain a specific consent. Invasive procedures and special treatments, such as immunizations, may require additional consents. I know that the practice of medicine is not an exact science and outcomes may be different for each patient.

Except as barred by any agreement between my insurance company and IU Indianapolis CH or by state or federal law, I understand that I will be responsible for the child's co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I assign all rights and benefits to IU Indianapolis CH in order to facilitate reimbursement for health care services. I will help IU Indianapolis CH follow up on these claims. I further understand and agree that IU Indianapolis CH may reach out to other IU Indianapolis offices, including the Financial Aid Office or Human Resources Office, to verify the child's ability or inability to pay costs not covered or paid by insurance or other third party payers.

I do also hereby authorize the release of medical record information related to the diagnosis and treatment, as the parent and/or guardian of the above named individual, to third party payers, institutions, or other physicians or providers who may render services or provide payment for the child's healthcare.

This consent is valid for 12 months or until the listed child reaches a legal age of 18 or is emancipated.

Printed Name of Parent/Guardian	Signature	Date

Relationship: □ Parent □ Legal Guardian

Statement of individual:

- I understand that my medical records are available to my parent and/or guardian until my eighteenth birthday.
- I understand I may revoke this authorization at any time and must do so in writing to IU Indianapolis Campus Health.

Printed Name of the Minor	Signature	Date