



CONSENT FOR EVALUATION AND/OR TREATMENT OF MINOR (to be completed by parent or legal guardian)

If student is under the age of 18 please complete this part of the form for the student to be seen as a patient and receive treatment without a parent or legal guardian. This consent is valid until the student is no longer enrolled at Detroit Mercy or after their 18th birthday, whichever occurs first.

Please note that this authorization is only valid for the Detroit Mercy Wellness Center. If the student seeks or is referred for care at an off-campus facility, the policies and procedures of that facility will apply.

It is the Detroit Mercy Wellness Center’s policy that all medical records and information be kept confidential. By signing this authorization you are agreeing that no protected health information pertaining to your student will be shared with the parent or legal guardian. No information will be released without written authorization of the student except some emergency and public health related situations.

I, _____ as the _____ of the Detroit Mercy
(name of parent or legal guardian) (“parent” or “legal guardian”)

student _____ do hereby authorize this student to independently seek
(name of student)

evaluation and/or treatment at the Detroit Mercy Wellness Center without the presence of a parent or legal guardian.

Student’s name (printed): _____ Student’s date of birth (mm/dd/yyyy): _____

Student’s T#: _____ Best contact phone #: _____

Parent or Legal Guardian’s signature: _____ Date: _____