

**Consent of a Minor to Release Medical Information to  
Parent or Guardian: Virginia**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize Piedmont Primary Care to release my medical information to:

\_\_\_\_\_ parent/legal guardian,  
(Name of parent/legal guardian)

\_\_\_\_\_ (address/phone number)

I understand that under Virginia law, as a minor, I am deemed an adult and can consent to my own treatment without the consent or notification of a parent or legal guardian for the purposes of:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease, which the State Board of Health requires to be reported.
2. Medical or health services required in case of birth control, pregnancy or family planning except for the purpose of sexual sterilization.
3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse.
4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance.

Notwithstanding my ability to consent to my own treatment for the above purposes, I want my parent/legal guardian named above to have access to my medical information and be consulted regarding my treatment. This authorization includes full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, dates of hospitalization and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease unless I specifically indicate its exclusion below.

Exclusions: \_\_\_\_\_

This authorization is valid for one year or until \_\_\_\_\_, whichever comes first.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Witness Signature: \_\_\_\_\_