Central Montana Family Planning
300 1st Ave No., Suite 202
Lewistown, MT 59457
(406) 535-8811 phone & fax
http://www.cmtfp.org

TEEN PATIENT
PARENTAL/GUARDIAN RELEASE

Date: _____

I, _____, hereby give my consent for my Mother and/or Father or Guardian to request (order refills either in person or via telephone), pick-up, and/or pay for my birth control method.

_____ (initials) Central Montana Family Planning staff may acknowledge to my Mother and/or Father or Guardian that I am a patient of Central Montana Family Planning if asked.

_____ (initials) Central Montana Family Planning staff may acknowledge to my Mother and/or Father or Guardian if I'm present at the clinic at the time of questioning.

_____ (initials) My Mother and/or Father or Guardian may schedule appointments for me (either in person or via telephone), and you may confirm my appointments with her/him.

This consent expires one year from the date above and I may revoke it at any time either verbally or in writing.

Signature: _____

Printed Name: _____

Witness: _____

Date of Birth: _____ Chart #: _____