Authorization for Treatment of an Emancipated or Self-Sufficient Minor

CSU Health Network (CSUHN) strives to provide a caring, safe, and inviting environment for students. Colorado status declare a student aged 13 years to 17 years old as a legal “minor”. CSUHN will follow Colorado Laws in allowing students within those ages to consent to their own health care if one of the two examples below applies.

- A self-sufficient minor: "a minor fifteen years of age or older who is living separate and apart from [their] parent, parents, or legal guardian, … and is managing [their] own financial affairs, regardless of the source of [their] income ... may give consent to …. the furnishing of hospital, medical, dental, emergency health, and surgical care to [themselves].
  Co Rev. Stat. § 13-22-103(1)

- A legally emancipated minor. Emancipation status must be proven with legal documents.

If the above statement(s) apply to you, sign the form and return to CSUHN Medical Records.

Be aware, minors can consent to several types of medical treatment under the law without needing either of the above circumstances to apply or parent or guardian authorization.

Consent from a parent or guardian is not needed for the following instances.
- Mental Health Treatment
- Substance Disorder Treatment
- Sexual Health Treatment
- Pregnancy related Care

____I affirm that the above definition of a self-sufficient minor applies to me, and I can consent to my own care.

OR

____I affirm that I am an emancipated minor by court order and can consent to my own care. I am attaching a copy of the court documents.

Signature ___________________________ Date ___________________________

Printed Name ___________________________ CSU Ram ID Number ___________________________
Authorization for Treatment of a Minor

I am the parent or guardian of ___________________________ (the “minor”) whose date of birth is __________ being entitled to the care and custody of the above minor, do hereby authorize, request and direct you to render treatment to said minor.

____ I authorize Colorado State University Health Network to provide health care to my minor, including but not limited to, diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, necessary medical treatment including minor surgical procedures, and venipunctures.

____ I understand that my minor child’s immunization records and/or results will be sent to the Colorado Immunization Information System (CIIS).

OR

____ I decline this information exchange by completing the CIIS Opt-Out Form. I acknowledge that it is my responsibility to complete and deliver the form to the CISS office. As well as to provide a signed copy to be part of my minor’s electronic health records.

____ I understand that I will be contacted should my minor’s needs require contacting a parent or guardian as specified by Colorado law.

____ I understand that, once my minor reaches the age of majority, my consent for treatment is no longer required.

Signature

Date

Printed Name

Relationship

CSUHN STAFF USE ONLY

Received verbal/phone authorization from: ____________________________

Relationship: ____________________________ Date: ____________________________

Reason: ____________________________

CSUHN staff signature: ____________________________