

Name: \_\_\_\_\_ USC I.D. #: \_\_\_\_\_

For the purposes of obtaining diagnosis or treatment at the Engemann Student Health Center, or by any physician, mental health professional or dentist associated with the clinic, the undersigned certifies the following facts are true (California Family Code § 6922):

1. I am 15 years of age or older, and was born on: Birth Date \_\_\_\_\_ mm / dd / yyyy

2. I am living separate and apart from my parents or legal guardian(s):

Patient's Street Address	Apt. #	Telephone Number
City	State	Zip Code
Parent/Guardian Place of Residence	Parent/Guardian Telephone Number	

3. I am managing my own financial affairs (i.e. I have my own checking account, credit card, etc.)

4. I understand that, under the law, I will be financially responsible for any charges for my clinical diagnosis, treatment and care and that I may not disaffirm this consent because I am a minor.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  AM  
Signature  PM

Witness: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature

Witness: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature