Dignity Health Medical Foundation

DHMF Clinical Support and Patient Safety Department

Self-Sufficient Minor Information

Form Revised: 04/25/2022

For the purpose of obtaining diagnosis or treatment at ______________________________
or by any Physician, or Surgeon associated with it, the undersigned certifies the following facts are true:

1. I am 15 years of age or older, having been born on ______________________________
   (insert date as mm/dd/yy)

2. I am living separate and apart from my parents or legal guardian.

______________________________	______________________________
(place of residence of patient)	(phone #)
______________________________	______________________________
(place of residence of parents or guardian)	(phone #)

3. I am managing my own financial affairs.

____
(place of employment)

____
(other sources of financial support – explain)

4. I understand I will be financially responsible for the changes for my medical diagnosis, treatment and care and that I may not disaffirm this contract on the grounds that I am a minor.

Date: ______________________________ Time: ______________________ AM/PM

____
Signed (patient)

____
Printed Name (patient)

Date: ______________________________ Time: ______________________ AM/PM

____
Signed (witness)

____
Printed Name (witness)

FORM TO BE SCANNED INTO AUTHORIZATIONS/CONSENTS FOLDER IN THE PATIENT'S EHR