Concord Feminist Health Center

Quality ~ Compassion ~ Respect - Since 1974

MINOR CONSENT:
RELEASE OF INFORMATION AUTHORIZATION

Name of client (please print) _____ Date of Birth _____

I authorize the Concord Feminist Health Center of Concord, NH to send a letter of notification to my parent/legal guardian (listed below) of my intention to terminate a pregnancy.

This authorization is valid for no more than 30 days from the date signed.

Name of Parent/Legal Guardian (please print) _____

Address _____

City _____

State _____ Zip Code _____

Signature of Patient _____ Date _____

This authorization may be revoked in writing at any time, except to the extent that the action has already been taken on sending the notification.