Haak'u Health Center

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PO Box 40 San Fidel New Mexico, 87049
Telephone (505) 552-5300 ~ Fax (505) 552-5478

PATERNAL CONSENT FOR MATERNITY CARE

Statement of Paternity Consent

I, ____ **(Father's Name)**, affirm that:

1. I am an enrolled member or otherwise eligible member of the Federal Recognized Tribe.
2. I acknowledge that ____ ***(Mother's Name)*** is currently pregnant and that I am the biological father of the unborn child.
3. I understand that my child will be eligible for services as a Native American child at **Haak'u Health Center** and the mother of my child will also be eligible to receive medical care related to the pregnancy at Haak'u Health Center for the duration of the pregnancy and postpartum care for up to six (6) weeks following delivery.
4. I understand that services provided under this consent are limited to pregnancy-related care for the benefit of the Native child, including but not limited to:
    - Prenatal care
    - Obstetric monitoring
    - Pregnancy-related lab testing and imaging
    - Pregnancy complications
    - Delivery coordination or referral
    - Postpartum care for up to six (6) weeks related to pregnancy
5. I understand that non-pregnancy-related services for the mother may not be covered under this consent.
6. I certify that the information provided is true and correct to the best of my knowledge.

Signature (Father): ___________________________________ **Date:** ______________________

Father Information (Native Parent) **Chart #:** ____________________

Full Name: ______________________________
Date of Birth: ______________________________
Address: ______________________________
Phone: ______________________________
Tribal Affiliation: ______________________________

Patient Information (Pregnant Mother) **Chart #:** ____________________

Full Name: ______________________________
Date of Birth: ______________________________
Address: ______________________________
Phone: ______________________________

Acknowledgment by Mother

I, ______________________________ **(Mother's Name)**, acknowledge that:

- I am receiving care at Haak'u Health Center because the Native father has acknowledged that I am pregnant with his Native child and has provided consent for me to receive pregnancy-related care.
- I understand the **scope of services is limited to pregnancy-related care and six weeks postpartum** unless otherwise authorized.
- I consent to receive such care from Haak'u Health Center.
- I understand I am PRC eligible for the duration of my pregnancy and postpartum treatment.

Signature (Mother): ______________________________ **Date:** ____________________

(OFFICE USE ONLY)

Clinic Verification:

Staff Name: ______________________________

- Enrollment Verified: ☐ **Yes** ☐ **No**
- Documentation Reviewed: ☐ **ID** and ☐ **Tribal Enrollment**
- **Signature:** ______________________________ **Date:** ____________________