CONFIDENTIALITY AGREEMENT AND PARENT/GUARDIAN CONSENT FOR ADOLESCENT REPRODUCTIVE HEALTH CARE

Patient Name: _____ Date of Birth:_____

The legal ability of minors to consent to a range of health care services including sexual, reproductive, and contraceptive health care can be confusing. While parental involvement in minors' health care decisions is desirable, many minors will not obtain these services if they are required to involve their parents. Indiana law states that any child under the age of 18 years old cannot consent to be treated by a medical provider. These services can be obtained by anyone over the age of 14 through federally funded programs such as Planned Parenthood (federal funding allows them to follow different guidelines). Patient care that is related to sexually transmitted diseases are the exception; minors can consent confidentially for these services in any state. Providing the best and safest care possible at Copas Health, adolescents are encouraged to develop an open and honest relationship with their parents as well as their provider. When adolescents know that what they share with the provider is confidential, it encourages a truthful dialogue. Parental input and involvement will always be encouraged, however, in some instances a confidential relationship may be in the best interest of the patient. Do you give Copas Health consent to treat your daughter and allow her to develop a confidential relationship with her provider? If the patient desires or the provider deems it in the best interest of the patient, you will be involved in her care.

I declare that I am the parent/legal guardian of the minor patient and that I have legal authority to grant this consent. By signing below, I allow my minor daughter to enter a confidential health care relationship and I consent for care at Copas Health. He/She has permission to schedule appointments and receive care from this office which may include exams as well as various laboratory and diagnostic tests necessary in accordance with standard medical protocols.

_____ _____ _____

Parent Printed Name Parent Signature Date

I understand that I am entering a confidential relationship with my healthcare provider at Copas Health. I will make an effort to communicate with my parent/legal guardian about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations that my provider and I establish.

_____ _____

Patient Signature Date

Please initial and CIRCLE your choice.

____ I give permission to release my protected health information to my parents/guardians.

(Initial)

____ I do not give permission to release my protected health information to my parents/guardians.

(Initial)