Confidentiality Agreement

Parent

I, _____ (parent/guardian), allow _____ (patient), to enter a confidential patient-physician relationship. I understand that she can make independent health care decisions, but that my input and involvement will be encouraged. _____ (patient) has permission to schedule appointments and receive confidential reports from this office. I further understand that various laboratory tests may be necessary in medical protocols and accept responsibility for physician charges and laboratory fees.

_____ _____

Parent or Guardian Date

_____ _____

Physician Date

Patient

I, _____ (patient), am entering a confidential physician-patient relationship with _____ (physician). I will make an effort to communicate with my parent(s) or guardian(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations my physician and I establish.

_____ _____

Patient Date

_____ _____

Physician Date

Revocation

We understand that this agreement will remain in effect until a written request of revocation is given to an employee of North Central Women's Health Partners.

_____

Patient Parent Date