Uptown Pediatrics
Adolescent Confidentiality Agreement

Parent

I, _____(parent or guardian), allow _____(patient), to enter a confidential patient-physician relationship. I understand that my son/daughter 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 Uptown Pediatrics. 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 patient-physician 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.

_____ _____
Parent or Guardian Date

_____ _____
Physician Date