Ob/Gyn Associates of Southern Indiana

1919 State St. #340

New Albany, IN 47150

812-945-5233

CONFIDENTIALITY AGREEMENT AND PARENT/GUARDIAN

CONSENT FOR ADOLESCENT REPRODUCTIVE HEALTH CARE

The legal ability of minors to consent to a range of sensitive health care services, including sexual, reproductive and contraceptive health care, has expanded dramatically. While parental involvement in minors’ health care decisions is desirable, many minors will not obtain these services if they are forced to involve their parents. Under Indiana law, any child under the age of 18 years old cannot consent to be treated by a private physician. Alternatively, these services can be obtained by anyone over the age of 14 through federally funded programs such as Planned Parenthood (their federal funding allows them to follow different guidelines). Services related to sexually transmitted diseases are the exception; minors can consent confidentially for these services in any state no matter where the services are performed.

These laws put providers in a predicament when it comes to taking care of these young ladies. In order to provide the best and safest care possible at Ob/Gyn Associates of Southern Indiana, adolescents are encouraged to develop an open and honest relationship with a physician. Trusting that what is disclosed with the physician is confidential 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. With this in mind, we ask that you give us consent to treat your daughter and allow her to develop that 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 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 patient-physician relationship and I consent for care at Ob/Gyn Associates of Southern Indiana. 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.

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Parent Printed Name Parent Signature Date

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I understand that I am entering a confidential physician-patient relationship with my healthcare provider(s) at Ob/Gyn Associates of Southern Indiana. 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.

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Patient Printed name Date of Birth Patient Signature Date

\_\_\_\_ 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)