

Atanassova-Lineva, Daniela, M.D., Pediatrics, P.C.
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.

_____ (patient) has permission to schedule appointments
and receive confidential reports from Atanassova-Lineva, Daniela Pediatrics office. I
accept responsibility for physician charges and laboratory fees and give permission for
diagnostic tests and procedures as required by the Doctor.

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