Parental Consent and Confidentiality Agreement

Parent/Guardian

I, _______________________, parent/guardian of _________________________ (patient), give my consent to allow ___________________ (patient) to enter into a confidential doctor-patient relationship with Dr. Sillay. Included in this consent is permission to make appointments, be examined, receive treatment, and receive confidential test results. I understand that Dr. Sillay will encourage open communication between _________________ (patient) and me, but that she must respect the confidentiality of the doctor-patient relationship.

I also understand that certain tests and procedures may be necessary according to medical protocols, and accept responsibility for all associated physician and laboratory charges.

Patient

I, ______________________ (patient) agree to enter into a confidential doctor-patient relationship with Dr. Sillay. Though I understand the confidentiality involved, I appreciate the benefits of open communication with my parent/guardian regarding my health and will attempt to maintain such openness. I also understand the benefits of such openness in my relationship with Dr. Sillay and will strive to have such a relationship, and will attempt to follow recommendations and treatment plans.

Signatures

____

Parent Date

____

Patient Date

____

Physician Date