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