Aloha Nui Family Practice, LLC – Adolescent Confidentiality Agreement Form

Confidentiality is the principle that information cannot be disclosed without the permission of the person who consented to care. In nearly all situations in which an adolescent has the right to consent to their own care, they also have the right to confidentiality.

Usually, the right to consent to treatment resides with the adolescent's parent(s) or legal guardian(s); however, there are many cases in which adolescents may provide their own consent.

Also, adolescent minors (age less than 18 years) have the right to confidentiality in almost all situations in which they have the right to consent.

1. **Adolescents may consent to their own care for emergency health care.**
2. **Adolescents may consent to their own care if they are pregnant, parenting, married or emancipated.**
3. **Adolescents may consent to their own care for birth control, family planning & reproductive health care.**
4. **Adolescents may consent to their own care for testing and treatment for sexually transmitted diseases, including HIV & AIDS.**
5. **Adolescents may consent to their own care for drug & alcohol abuse services.**
6. **Adolescents may consent to their own care for consultation of, but not treatment for, mental health services**.

Aloha Nui Family Practice & its staff, once they provide the confidential service, cannot legally share any information with the parent(s), legal guardian(s) or any other person(s) without the explicit agreement of the adolescent.

However, confidentiality can and must be breached if the adolescent is a threat to themselves or to the health of others.

Aloha Nui Family Practice & its staff are required by law to report any signs of child abuse or neglect to the appropriate welfare agency, and any manifestations of criminal activity involving a minor to a legal authority.

Name of adolescent: ____

Name of parent or legal guardian: ____

Signature of parent or legal guardian: ____

****By signing above I understand & agree to the above policy of adolescent consent & confidentiality established by Aloha Nui Family Practice, LLC in accordance with the laws of the State of Hawaii.**

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Please list all persons who have parental or legal guardian consent to bring the above named adolescent to Aloha Nui Family Practice, LLC for non-confidential medical appointments.

Name:	Relationship:
1.	
2.	
3.	
4.	
5.	
6.	

****Please mark only one ☐ *Yes* or ☐ *No* the above listed adolescent can schedule & attend non-confidential medical appointments by themselves. Otherwise will need to be accompanied by an above listed adult at each appointment.**