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ADOLESCENT CONFIDENTIALITY POLICY

At GROW Pediatrics, we want to recognize and support our teenage patients' evolving maturity and independence as they transition toward adulthood.

To provide the best care possible for our adolescent patients, we want our teens and parents to be aware of the following:

- During our adolescent well visits, **we will have part of each visit alone with our teens**. This time alone with the provider gives the patient a chance to address any concerns or issues.

  We see this as an opportunity for teens to become more comfortable speaking alone with their healthcare provider, as they will need to do independently once they are adults themselves. We also want to give all teens an opportunity to address any and all of their healthcare concerns in a private and confidential manner.

- **When teens share something with us that they ask to remain confidential, we will honor that request,** unless they plan to harm themselves or someone else. Although we always encourage patients to be open and honest with their parents, we also want them to have a safe place to go with any health concerns. We hope that parents will trust us to take the best care of your teens.

- **We are also happy to speak privately with parents** during the visit, at their request, about any concerns that they may want to share with us about their teen. **We will maintain the patient's confidentiality in these discussions.**

- These confidentiality parameters also **extend to any telephone calls** that we may have with our patients about their healthcare, including discussions about appropriate lab/imaging evaluations and results.

- When our patients turn 16 years old, we follow state and federal guidelines mandating that they make decisions about how and with whom their medical information is shared. We will require their consent to discuss any information about prescriptions, appointments, referrals and visits.

SIGNATURE OF PATIENT

Signature of Patient **Date**

Printed Name of Patient **Date of Birth**

SIGNATURE OF PARENT/LEGAL REPRESENTATIVE

Signature of Parent/Legal Representative **Date**

Printed Name of Parent/Legal Representative **Relationship to Patient**