

Adolescent Confidentiality / Release Form

(Individuals 12-17 years of age)

Patient Name	Date of Birth	Cell phone#
Street Address	City	State Zip

I understand that certain mental health, sexual/reproductive health, and substance abuse services information that I discuss with my provider will be confidential. I may limit authorization for ConnexxCare to speak with my parent(s)/guardian(s) regarding my medical care or, I may authorize ConnexxCare to communicate fully with my parent/guardian. **I also understand that in certain situations providers may be bound by law to disclose information.**

I hereby authorize ConnexxCare to communicate or release the following information to my parent/guardian listed on this form (check all that apply):

You can choose to allow full access to your parent or guardian:

☐ **FULL ACCESS** to my patient portal and medical records

Or, you can limit information to (check all that apply):

- ☐ **SHARE** Appointment scheduling & reminders
- ☐ **SHARE** Medication requests/refills
- ☐ **SHARE** Referrals
- ☐ **SHARE** Insurance/billing
- ☐ **DO NOT SHARE** Medical care/treatment/lab results of (Check all that apply):
 - ☐ Substance/Alcohol use or treatment,
 - ☐ Sexually Transmitted Disease (STD),
 - ☐ Reproductive health care including birth control, abortion, pregnancy, etc.
 - ☐ Genetic testing,
 - ☐ HIV testing, AIDS diagnosis/treatment,
 - ☐ Mental Health Treatment,
 - ☐ Gender Identity and/or Transgender counseling and/or treatment
 - ☐ Other protected information (please specify) _____

Name(s) of Parent/Guardian/Advocate: _____

Relationship to patient: ☐ Parent(s) ☐ Other _____

Address: _____

Telephone(s) #: _____

This authorization will expire upon written revocation or once I have left the practice of ConnexxCare. I understand that **I may revoke this consent at any time** by completing a new copy of this form. I also understand that such revocation does not affect any actions previously taken by ConnexxCare.

Signature: _____ Date: _____