orchidhealth

MINOR CONFIDENTIAL PREFERENCE FORM

Please indicate your confidentiality for this visit: _____ (date of visit to remain confidential)

☐ I want my visit and records to remain confidential and not shared with my parent/guardian.

☐ I agree my parent/guardian may be involved or notified

Signature (Minor): _____ Date:_____

** Staff / Provider acknowledgement

Provider staff have reviewed Oregon law on minor self-consent and confidentiality with this patient. Confidentiality preference will be honored as allowed by law.

Signature (Staff / Provider): _____ Date: _____