South Cove Community Health Center
Statement of Confidentiality & Consent for Teen Services

I understand that Massachusetts law allows minors (person age 17 and younger) to consent to and obtain limited health care services without parental or guardian consent or knowledge.

I understand that I can receive examination, diagnosis and treatment for those limited services in a confidential manner and that my parent or legal guardian does not have a right to know.

These services include:

- Birth control/contraceptive care
- Pregnancy testing and/or assistance for care during or after a pregnancy
- Diagnosis and treatment of sexually transmitted diseases (STDs)
- HIV counseling and testing
- Counseling and health education for any of the above services

I also understand that other services I may want to receive at SCCHC do not fall under my right to consent as a minor, and that my SCCHC provider will need to make an attempt to obtain legal consent from my parent or legal guardian.

These services include:

- Routine preventive health physicals
- School physicals
- Routine illness treatment (such as for the flu, asthma or ear aches)

I further understand that in rare situations my SCCHC provider cannot protect my confidentiality.
Examples of this include:

- If am at risk for hurting myself or other people
- If I am being abused

I understand the above information and am signing this document to consent to confidential services.
Because I do not want my parent or legal guardian to become aware of my receiving such services,
I will provide SCCHC with alternative means for contacting me (cell phone, school phone).
I agree to review this form at least once a year.

Patient name (print): _____ SCCHC Medical Record #:_____
Patient signature: _____ Date signed: _____
Provider/RN/Family Planning Counselor name: _____
Provider/RN/Family Planning Counselor signature: _____ Date signed: _____

I am not a Confidential Teen.
I understand the above agreement and do not desire confidential care as a minor.
I agree to review this form at least once a year:
Patient name (print): _____ SCCHC Medical Record #:_____
Patient signature: _____ Date signed: _____
Provider/RN/Family Planning Counselor name: _____
Provider/RN/Family Planning Counselor signature: _____ Date signed: _____