Over 18 HIPAA Release and Consent Form

Patient Name:	Date of Birth:

I understand and acknowledge that as of my 18th birthday, my parents and / or guardians will no longer be permitted access to my medical records, information, providers or appointment status without my specific written permission. WingHaven Pediatrics will not speak with my parents, permit my parents to schedule appointments or release medical information to my parents without my written consent in accordance with this document.

□ I WISH TO grant my parents and or/ guardian access to my healthcare providers and / or medical information as follows:

Print Name of Parent or Guardian	Relationship to you

□ I give the above-named individuals(s) permission to act on my behalf with NO limitations, including sexual and mental health and substance use history. I understand that they may contact any physician or member of the staff at Winghaven Pediatrics to schedule appointments, discuss my healthcare and access my complete medical records. **THEY HAVE NO RESTRICTIONS.**

□ I give the above-named individuals(s) permission to act on my behalf with limitations, please check appropriate boxes: □sexual health □ Mental Health □ Substance use history. I understand that they may contact any physician or member of the staff at WingHaven Pediatrics to schedule appointments, discuss my healthcare and access my complete medical records. **THEY HAVE SOME RESTRICTIONS.**

□ I give the above-named individuals(s) permission to contact and speak with any physician or member of the staff at WingHaven Pediatrics for the sole purpose of scheduling an appointment. NO access to my medical record or information regarding my care can be discussed or provided. **APPOINTMENT ACCESS ONLY.**

□ I give the above-named individual(s) permission to request refills and pick up my prescriptions.

□ **I DO NOT** grant any access to my parents and / or guardians. **No medical information records or appointment information can be discussed or released.**

This content if valid from date signed. I understand that I can withdraw this consent at any time in writing.

Patient Signature:	**Date:**

Over 18 COMMUICATION AUTHORIZATION REQUEST

AND PATIENT RECORD OF DISCLOSURES

Patient Name:	DOB:

I wish to be contacted in the following manner: (PLEASE CHECK ALL THAT APPLY)

	Cell Phone Number:	
	Ok to leave a message with call back number	
	DO NOT leave a message	

	Home Telephone Number:	
	Ok to leave a message with call back number	
	DO NOT leave a message	

	Written communication :	
	Ok to email me:	Email address:

Patient Signature:	Date: