



18 & Over – HIPAA Release and Consent Form

As of my 18th birthday, I understand that my parents and/or guardians will no longer have access to my medical records, information, appointment status, or be able to communicate with my healthcare providers without my specific written permission.

Pampa Pediatrics will not release any medical information, schedule appointments, or discuss my care with my parent(s)/guardian(s) without my written consent as outlined in this form.

Authorization Duration

This authorization is valid through:

- ☐ My 21st birthday _____ (initials)
- ☐ One year from today's date: _____ (date and initials)
- ☐ Specific expiration date: _____ (date and initials)

Access Preference

Please indicate your choice below:

- ☐ I DO NOT grant any access to my parents and/or guardians. No medical information, records, or appointment details may be discussed or released. _____(initial)
- ☐ I DO wish to grant access to the following individual(s) to schedule appointments, speak with providers, and access my medical records:

(Print full names and relationships)

1. _____ 2. _____

Permission Details

Please initial YES or NO next to each item below to indicate your preference:

- All Lab Work:
Yes _____ No _____ (initial)
- Billing:
Yes _____ No _____ (initial)
- Office Visits:
Yes _____ No _____ (initial)
- Portal (grant proxy access):
Yes _____ No _____ (initial)

Patient Acknowledgement

I understand that:

- I am authorizing the release of my health information as specified above.
- I am not required to sign this form to receive care.
- The information disclosed may be subject to redisclosure and may no longer be protected under HIPAA.
- I have the right to revoke this authorization in writing at any time, except where actions have already been taken. Revocation requests should be submitted to: Privacy Officer, Pampa Pediatrics 2155 Post Oak Tritt Rd Suite 100 Marietta, GA 30062

Note: This form may be deemed invalid if all required sections are not completed.

Patient Signature: _____ Printed Name: _____
Date of Birth: _____ Patient email: _____
Patient Cell Phone: _____ Date: _____