PEDIATRIC PARTNERS, LLC

HIPAA Release and Consent Agreement for Patients 18 Years and Older

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will not be permitted to have access to my medical records or information about my care without my specific written permission.

I wish to grant my parent(s)/guardian(s) access to my healthcare providers, appointment and/or medical information as follows:

(Please print the name(s) and relationship of those who may act on my behalf)

Name: _____*Relationship*_____

Name _____*Relationship*_____

Please select and initial one of the following options:

_____ **I give the above-named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or staff member at Pediatric Partners to schedule appointments, discuss my healthcare and access my medical records. THEY HAVE NO RESTRICTIONS.**

_____ **I DO NOT GRANT ANY ACCESS TO MY PARENT(S)/GUARDIAN(S). NO MEDICAL RECORD OR INFORMATION MAY BE ACCESSED OR DISCUSSED. NO APPOINTMENT INFORMATION MAY BE RELEASED.**

This consent will be valid for one year from the date signed. I understand that I may withdraw or change my consent at any time by submitting a new written consent form indicating the changes in access.

Patient Name: _____

Patient Signature: _____ ***Date:*** _____

Witness: _____

Witness Signature: _____ ***Date:*** _____

Patient Cell: _____

Patient Email: _____