Authorization For Use and Disclosure of Medical Information
18-22 years

Now that you have turned 18, we need your permission to discuss with or give any medical information to your parents/guardians.

Printed Name of Patient:_____

Date of Birth:_____

MY AUTHORIZATION

I authorize **CONEJO CHILDREN'S MEDICAL GROUP**

To use or disclose the following health information:

( ) All of my health information

( ) My health information except relating to the following treatment or condition:

_____

( ) Other- making appointments, requesting refills, test results and other related information

The above party may disclose this health information to the following recipient(s):

_____

_____

_____

DURATION

This authorization shall be effective immediately and remain in effect until _____**Date**

_____ _____

Patient Signature **Date**