johnson county pediatrics
An Affiliate of Children's Mercy

18 and Older HIPAA Release and Consent

Instructions on reverse side

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Complete to permit the disclosure of information to Parent/Guardians if Patient is 18 years and older)
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. AUTHORIZATION (Must complete if authorizing release of information)

By signing this authorization, I authorize Johnson County Pediatrics to use and/or disclose certain protected health information (PHI) about me to:_____

(Person(s) you'd like information to be released to)

Their relationship to you:

2. EFFECTIVE PERIOD:

This authorization for release of information covers the period of healthcare from:

A:	☐	Start Date:	End Date:
OR			
B:	☐	All past, present, and future periods	

3. EXTENT OF AUTHORIZATION:

A:	☐	I DO NOT authorize the release of my health record.
OR		
B:	☐	I authorize the release of my complete health record (including but not limited to records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
OR		
C:	☐	I authorize the release of my complete health record with the exception of the following information (please mark all that apply):
		☐ Mental health records; ☐ Communicable diseases (including HIV and AIDS); ☐ Alcohol/drug abuse treatment; ☐ Other (Please specify): _____

4. This authorization shall be in force and effect for one (1) year from the date signed or _____, (date or event), *at which time this authorization expires*;

5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct;

6. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage at the insurer has a legal right to contest a claim;

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization;

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature:	Date:
Patient Printed Name and Date of Birth:	Patient's Telephone #:

Form 7.0c

8800 W. 75th Street, Suite 220, Shawnee Mission, KS 66204
Phone: 913-384-5500 Fax: 913-384-5209 www.jocopediatrics.com

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The purpose of this form is to allow others, typically your parents/guardians, to have access to your medical record now that you are 18 or older. Without this form being completed only **you** can request items from your record, that includes vaccinations, appointment dates, and limits all communications from the doctor only to you. This authorization will last for **1 year**; we will include this form at every visit/appointment after you turn 18 to ensure that the authorization is up to date.

Section 1:

This is where you will fill out who you want to have access to your records, typically parents/guardians. Please fill in their first and last name and fill in their relationship to you.

Section 2:

Option A is if you want to only disclose information from a certain time period. You might choose to limit access to newer information, or information from specific time periods.

Option B is if you want to include **all** your information in this release. Now that you are 18+, even your information from before turning 18 is considered yours only.

Section 3:

Option A is if you do not want anyone to have access to your records. Only you will be able to request information or specific details at any time. If you want anything done with your records, you must be the one to sign any and all releases and make the requests.

Option B is if you want to authorize the release of your records to the named person(s) in section 1. They may request any and all records without limit or restriction.

Option C is if you want to authorize the release of your records, but with restrictions. The person you authorize may request things like vaccination records, and certain notes; but for your privacy, things will be stricken out if that is what you request.

Section 4:

Only fill in this option if you would like this authorization to start at a specific date other than today's date.

At the bottom of the reverse side please sign and print your full name and include your date of birth as well as today's date and your personal phone number.

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