



FORT WAYNE PEDIATRICS

18+ YEAR OLD AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO PARENT/CAREGIVER

Patient Name: _____ Date of Birth: _____ Cell # _____

I request and authorize Fort Wayne Pediatrics to release healthcare information of the patient named above to Parent/Caregiver(s):

Parent/Adult 1 Name: _____ Relationship: _____

Address: _____

City, State, & Zip Code: _____ Phone: _____

Parent/Adult 2 Name: _____ Relationship: _____

Address: _____

City, State, & Zip Code: _____ Phone: _____

This request and authorization includes:

- All Healthcare information including Lab results and Diagnostic Imaging.
- Other (Please Specify): _____

Sexually Transmitted Disease (STD) includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of the results of my STD, HIV/AIDS testing, pregnancy testing, whether negative or positive, to the person(s) listed above.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Yes No I understand that test orders will be visible on my billing statements and insurance explanation of benefits, and will be visible to my authorized parent/caregiver if they are listed below as financially responsible.

I understand and have been provided access to the Notice of Privacy Practices.

Patient Signature: _____ Date Signed: _____