VALLEY PEDIATRIC MEDICAL GROUP

Patient Responsibility Agreement Over 18 HIPAA Release and Consent

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status, without my specific written permission. Valley Pediatric Medical Group will not speak with my parents, permit my parents to schedule appointments or provide medical information to my parents unless in accordance with this document.

You must select only ONE option below and initial.

_________**I HEREBY GRANT** the below named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Valley Pediatric Medical Group to schedule appointments, discuss my healthcare and access my medical records.

PRINT THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF

______________________________________ ______________________________________

(Print name of parent or guardian) (Indicate Relationship)

______________________________________ ______________________________________

(Print name of parent or guardian) (Indicate Relationship)

_________**I DO NOT GRANT** any access to my parents or guardians.

NO MEDICAL INFORMATION, RECORDS, APPOINTMENTS INFORMATION CAN BE RELEASED.

This consent is valid for one (1) year from the date signed. I understand that I can withdraw consent at any time by providing Valley Pediatric Medical Group with a written consent indicating the changes in access.

______________________________________ ____________________

Patient Name (Print legibly) Date

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Patient Signature

Patient Cell # ____________________________ Patient Email ______________________________