TRIANGLE PEDIATRICS

Patient Responsibility Agreement Over 18 HIPPA 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, online portal, or appointment status without my specific written permission. Triangle Pediatrics Center 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 and initial)

_____ I give the named individual(s) listed below permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Triangle Pediatrics Center to schedule appointments, discuss my healthcare and access my medical records and online portal. THEY HAVE NO RESTRICTIONS.

(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 **ANYONE** access to my medical information, records, online portal or appointment information.

_____

PRINT PATIENT NAME **PATIENT D.O.B.**

(___)_____ _____

PATIENT CELL PHONE NUMBER **PATIENT EMAIL ADDRESS**

_____

PATIENT SIGNATURE **DATE**