Consent for Release of Medical Information

for Patients 18 Years of Age and Older

Patient Name _____ DOB (MM/DD/YY) _____

Patient's Email _____ Patient's Phone # _____

Upon turning 18 years of age, our patients obtain full control over their medical records in accordance with HIPAA policy. The purpose of this document is to give you the option to allow the release of your medical information to selected individuals at your discretion, which may be modified or revoked in writing at any time.

By signing this document:

1. I understand that I have the option to keep my records confidential since I am 18 years of age or older.
2. I acknowledge that this authorization will expire on my 21st birthday.
3. I authorize Peachtree Park Pediatrics to disclose and discuss any of my medical information to the following person(s):

Name of Authorized Individual _____ Relation to Patient _____

Name of Authorized Individual _____ Relation to Patient _____

The information being released should be limited to: (Place Xs by choices)

____ ALL medical records (if marked, you DON'T need to mark the rest)

____ Doctor's/Progress Notes

____ Laboratory/Clinical Results

____ Prescription History

____ Immunization records only

____ May request/pick-up prescriptions on my behalf

____ Telephone communications

____ I do not consent to ANY of my medical information being released

Patient's Signature _____ Date of Signing _____