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## Patients 18 years or older Authorization to Release Healthcare Information to Parent/Care Giver

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_

Patient's Cell Phone: \_\_\_\_\_

I request and authorize Pediatric Care Corner P.C. to release healthcare information of the patient named above to Parent/Care Giver:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

This request and authorization applies to:

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.

Financial Responsibility/Billing Statements should be sent to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_