

San Diego Uptown Pediatrics Medical Group

3500 5th Avenue Suite 101

San Diego, CA 92103

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**18 Years and Over HIPAA Release and Consent Form**

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. San Diego Uptown Pediatrics will not speak with my parents, permit my parents to schedule appointments, or release medical information to my parents without my written consent in accordance with this document. I understand that in the event that I grant access to my parents and/or guardians, in accordance with California state law treatment for the following conditions will remain confidential: sexually transmitted diseases, pregnancy, contraception, substance abuse, and mental health disorders.

\_\_\_\_\_ I **DO NOT** grant any access to my parents and/or guardians. No medical information, records or appointment information can be discussed or released. For the purpose of helping me with my healthcare,

\_\_\_\_\_ I **WISH TO** grant my parents and/or guardian access to my healthcare providers and/or medical information as follows: I give the below-named individual(s) permission to act on my behalf. I understand that they may contact any physician or member of the staff at San Diego Uptown Pediatrics to schedule appointments, discuss my healthcare, and access my medical records.

Print name(s) of the parent(s) or guardian you wish to grant access:

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I understand that I have the right to revoke this authorization at any time. The revocation must be submitted in writing to San Diego Uptown Pediatrics at 3500 5th Avenue Suite 101 San Diego, CA 92103.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Cell Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_