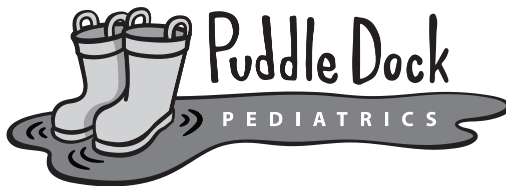

Over 18 HIPAA Release and Consent Form

Patient Name: ____ Date of Birth: __________________________

Phone Number: ___________________________________

Email: ____

I understand and acknowledge that as of my 18th birthday, my parents and / or guardians will no longer be permitted to access my medical records, information, providers, or appointment status without my *specific written* permission as indicated below. Puddle Dock Pediatrics will not speak with my parents/guardians, permit my parents/guardians to schedule appointments or release medical information to my parents/guardians without my written consent in accordance with this document.

Access granted to (list names):

____

____

PLEASE SELECT <u>ONE</u> OPTION BELOW

1. ____ I give the 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 Puddle Dock Pediatrics to schedule appointments, discuss my healthcare, and access my complete medical records. **FULL ACCESS, NO RESTRICTIONS**.

2. ____ I give the named individual(s) permission to contact and speak with any physician or member of the staff at Puddle Dock Pediatrics for the sole purpose of scheduling appointments and refilling/picking up prescriptions. **APPOINTMENT AND PRESCRIPTION ACCESS ONLY**.

3. ____ I give the named individual(s) permission to act on my behalf **WITH limitations**. I understand that they may contact any physician or member of the staff at Puddle Dock Pediatrics but **NOT in regard to** (check what is appropriate):

   ___ Mental Health ___ Sexual Health/History ___ Birth Control

   ___ Sexual Orientation or Identification ___ Pregnancy ___ Drug/Alcohol Use

   ___ Sexually Transmitted Infections (STI's) ___ HIV/AIDS ___ Access to Patient Portal

   ___ Scheduling Appointments ___ Other ____________________________________

4. ____ **I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIANS**. No medical information, records, or appointment information can be discussed or released.

Patient Signature: ____ Date: ______________________