HIPAA Release and Consent For Patients Over Age 18

I understand that as of my 18th birthday, my parent(s)/guardian(s) will no longer be permitted to access my medical records. Professional Park Pediatrics will not provide any medical information to my parents unless I permit them to do so in this document.

I wish to grant my parent(s)/guardian(s) access to my medical information as follows:

Print the name(s), phone number(s), and relationship(s) of those who may act on your behalf.

□ Mom □ Dad □ Other:__________________ **Permission:** □ **Yes** □ **No**

Name:____ Phone Number:____________________

□ Mom □ Dad □ Other:__________________ **Permission:** □ **Yes** □ **No**

Name:____ Phone Number:____________________

□ Mom □ Dad □ Other:__________________ **Permission:** □ **Yes** □ **No**

Name:____ Phone Number:____________________

_____ I give the above-named permission to act on my behalf **with no limitations** as indicated above. I understand that they may contact and/or be contacted by the staff at Professional Park Pediatrics to discuss my healthcare and access my medical information.

_____ I **DO NOT** grant access to my parent(s)/guardian(s) to my medical information. No information may be released without my written consent.

____________________________________ ____________________

Patient Name (Print Legibly) **Date**

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Patient Signature