Giving Tree Pediatrics

PATIENT 18yrs+ 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. Our providers will not speak with my parents or provide medical information unless specifically authorized by me.

I grant my parents and/or guardians access to my healthcare providers and/or medical information as follows: (You must select only ONE option and initial).

PRINT THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF:

_____ _____

PRINT NAME RELATIONSHIP

_____ _____

PRINT NAME RELATIONSHIP

☐ **THERE ARE NO RESTRICTIONS** (You may discuss any medical information with my parents and/or guardians)

☐ **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS.** (Please do not discuss any of my medical information with my parents and/or guardians)

☐ **LIMITED ACCESS ONLY.** (The following aspects of my care may **not** be discussed with my parents and/or guardians:

_____

☐ This Consent is valid until I age out of this practice/ transfer to a new physician:

☐ This Consent is valid for one year: ☐ Other:_____

_____ _____

PATIENT NAME (PRINT) DOB

_____ _____

PATIENT SIGNATURE DATE