18 years & Over HIPAA Release and Consent Form

At age 18, I, _____, acknowledge that my parents and/or guardians are not authorized access to my medical records (medical treatment, lab results, etc.) or appointment status unless I grant them permission. West Plano Pediatrics will not discuss with or release medical records to, or allow scheduling of appointments by any persons other than myself without the following authorization.

This Authorization will be valid through 21 years of age (Y/N) _____ , or until date: ____/____/_____

Please initial:

_____ I **DO NOT** authorize my parents and/or guardians to be granted access to my medical records. Appointment status cannot be released or discussed.

_____ I **DO** authorize my parents and/or guardians to be granted access as follows:

The below individual(s) are permitted access to my medical records and appointment status.

Name	Relationship	Cell Phone
_____	_____	_____-_____-_____
_____	_____	_____-_____-_____

Please initial next to the information you would like to be released:

_____ Mental Health Records

_____ Drug, Alcohol, or Substance Abuse Records

_____ Sexually Transmitted / Communicable Diseases

_____ Other (please specify): _____

_____

I authorize release of medical records for:

_____ ALL past and future records _____ Past records ONLY _____ Future records ONLY

Patient Information

Last Name: _____ First: _____

Date of Birth _____/_____/_____ Cell Phone: _____-_____-_____

Email Address: _____

Signature: _____ Date: _____/_____/_____