PEDIATRICS, LTD.

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Authorization for Use and Disclosure of Protected Health Information for Adult Patients

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. ABC Pediatrics, Ltd. will not speak with my parents and/or guardians, permit my parents and/or guardians to schedule appointments, or release medical information to my parents and/or guardians without my written consent in accordance with this document.

☐ **I DO NOT** grant any access to my parents and/or guardians. NO medical information, records or appointment can be discussed or released.

For the purpose of helping me with my healthcare,

☐ **I WISH TO** grant my parents and/or guardians 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 a physician or member of the staff at ABC Pediatrics, Ltd. to schedule appointments, discuss my healthcare, and access my medical records.

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

Please specify if you wish to include the following:

Sexually transmitted disease/communicable diseases	☐Yes, include	☐No, do not include
Pregnancy/sexual activity	☐Yes, include	☐No, do not include
Mental Health	☐Yes, include	☐No, do not include
Substance abuse	☐Yes, include	☐No, do not include

Please list any other information to exclude:

_____

My written revocation must be submitted to the Privacy Officer at ABC Pediatrics, Ltd.

Printed name	Date
Signature	Expiration Date

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