NAME:_____ ACCT#_____

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 or personal history information without my written permission. Pediatric Associates, LLC will not provide medical information to my parents unless in accordance with this document.

I wish to grant my parents and/or guardians access to my medical information as follows:

_____

PRINT NAME OF PARENT/GUARDIAN, INDICATE RELATIONSHIP

_____

PRINT NAME OF PARENT/GUARDIAN, INDICATE RELATIONSHIP

(You must select only ONE option and initial).

_____ I give the above named individual(s) permission to act on my behalf with no limitations. I understand they may contact any physician or member of the staff at Pediatric Associates, LLC to schedule appointments, discuss my healthcare and access my medical records. **THEY HAVE NO RESTRICTIONS.**

_____ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Pediatric Associates, LLC to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS.**

_____ I give the about named individual(s) permission to contact and speak with any physician or member of Pediatric Associates, LLC for the sole purpose of scheduling an appointment. No access to my medical records or information regarding my care can be discussed or provided. **APPOINTMENT ONLY ACCESS.**

____ I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIAN. NO MEDICAL INFORMATION, RECORDS OR APPOINTMENT INFORMATION CAN BE RELEASED.

This consent is valid for one (1) year from the date signed. I understand that I can withdraw consent at any time by providing Pediatric Associates, LLC with a written consent indicating the changes in access.

_____ _____

PATIENT NAME (PRINT LEGIBLY) DATE

_____

PATIENT SIGNATURE

_____ _____

HIPAA OFFICER SIGNATURE DATE

O INFORMATION NOTATED IN SYSTEM