Carolyn A. Clark, MD Bryan R. Holland, MD Ruth A. Loomis, MD
Julie E. Schiff, MD Adam S. Mastrocola, MD

# 18 & OVER CONSENT

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 guardians/others (list below) 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).**

_____ **NO RESTRICTIONS**: 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.

_____ 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.**

(See other side)

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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