Over 18 year old 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 or appointment status without my specific written permission. Chestnut Hill Pediatrics cannot speak with my parents/guardians; permit them to schedule appointments, or release medical information 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 INFORMATION CAN BE DISCUSSED OR RELEASED.**

I WISH TO grant my parents and/or guardian access to my healthcare providers and/or medical information as follows:

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____
(Print Name of second parent or guardian; indicate his/her relationship to you.)

_____ I give the above-named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Chestnut Hill Pediatrics to schedule appointments, discuss my healthcare, request medication refills, and access my complete medical records. **NO RESTRICTIONS.**

_____ I give the above named-individual(s) permission to contact and speak with any physician or member of the staff at Chestnut Hill Pediatrics for the sole purpose of scheduling an appointment. NO access to my medical record or information regarding my care can be discussed or provided. **APPOINTMENT ACCESS ONLY.**

_____Other

This consent is valid for 5 years from the date signed. I understand that I can withdraw consent at any time by providing Chestnut Hill Pediatrics with written notice indicating the changes in access.

Patient Printed Name: _____

Patient Signature: _____ Date:_____

Patient Cell Phone: _____