MR#_____

Over 18 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, information, providers, or appointment status without my specific written permission. Children's Healthcare Associates (CHA) will not speak with my parents, permit my parents to schedule appointments or release medical information to my parents 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 & phone number of the parent or guardian; indicate his/her relationship to you)

_____

(Print name & phone number 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 CHA to schedule appointments, discuss my healthcare, and access my complete 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 CHA 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.

_____ I give the above-named individual(s) permission ***to request refills and pick up my prescriptions.***

_____ _____

PATIENT PRINTED NAME DATE

_____ _____

PATIENT SIGNATURE CHA EMPLOYEE WITNESS

This consent is valid for one year from the date signed . I understand that I can withdraw consent at any time by providing Children's Healthcare Associates with written notice indicating the changes in access. Effective Date: _____