KIDS FIRST
PEDIATRIC PARTNERS

18 & Over - 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. Kids First Pediatric Partners will not speak with my parents or release medical information to my parents without my written consent in accordance with this document.

Patient Name: _____ **Patient Date of Birth:** _____

Address: _____

Telephone: _____ **Email:** _____

- This Authorization will be valid until:
  - ☐ 22nd birthday
  - ☐ One year from TODAY'S DATE: _____
  - ☐ The following DATE: _____

- For the purpose of helping me with my healthcare,

  _____ I WISH TO grant any access to my parents and/or guardian 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 any physician or member of the staff at Kids First Pediatric Partners to:
  - ☐ Discuss my healthcare
  - ☐ Access my patient portal

- They may have access to the following confidential information:

Sexually Transmitted Disease/Communicable Diseases	☐ Yes	☐ No
Pregnancy/Sexual Activity	☐ Yes	☐ No
Mental Health	☐ Yes	☐ No
Substance Abuse	☐ Yes	☐ No

_____

(Print Name of the parent or guardian; indicate relationship to you.)

_____

(Print Name of second parent or guardian; indicate relationship to you.)

I understand that:

1. These options are specified above so that I can make a decision as to whether to allow the release of
2. information.
   The disclosing office will not receive payment or other remuneration from a third party in exchange for using
3. or disclosing the past medical information, except for minimum fees for copying postage.
4. I do not have to sign this authorization in order to receive treatment.
   When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule or other law protecting its
5. confidentiality.
   I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this
6. authorization, I must do so in writing and present my written revocation to Kids First Pediatric Partners.
   This form may be deemed INVALID if all sections are not completed.

_____	_____	_____
PATIENT SIGNATURE	PATIENT PRINTED NAME	DATE OF BIRTH