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. BRENTWOOD PEDIATRICS 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.

_____ Please initial that you have received the ADVANCE DIRECTIVES information.

_____ 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.)

THEY HAVE NO RESTRICTIONS

_____ 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 BRENTWOOD PEDIATRICS to schedule appointments, discuss my healthcare, and access my complete medical records.

APPOINTMENT ACCESS ONLY

_____ I give the above named-individual(s) permission to contact and speak with any physician or member of the staff at BRENTWOOD 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.

_____ _____
PATIENT PRINTED NAME DATE

_____ _____
PATIENT SIGNATURE BRENTWOOD ASSOCIATE WITNESS

This consent is valid for one year from the date signed. I understand that I can withdraw consent at any time by providing BRENTWOOD PEDIATRICS with written notice indicating the changes in access.

Effective: April 20, 2018