Live Well Pediatrics

Over 18 HIPAA Release and Authorization 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 inquire about appointment status without my specific written permission. Live Well Pediatrics will not release medical information to my parent without my written authorization in accordance with this document.

____ **I DO NOT** grant any access to my parents and/or guardians. No medical information, records or appointment status 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 indicated below:

____
(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 wish to grant my parent/guardian(s) **FULL ACCESS** to see and discuss my medical records with staff and providers in the office or through the patient portal.

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

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PATIENT PRINTED NAME	DOB
PATIENT SIGNATURE	DATE
PATIENT CONTACT NUMBER	EMAIL

I acknowledge that I have received the Notice of Privacy Practices____. (Initials)

This authorization is valid for one year from the date signed. I understand that I can withdraw consent at any time by providing Live Well Pediatrics with written notice indicating the changes in access. I understand that authorizing this disclosure of this health information is voluntary.

I need not sign this form to assure healthcare or treatment. I understand that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.