Pediatric Associates

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. Pediatric Associates of Greater Salem (PAGS) 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 without restrictions 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.)

_____ _____
PATIENT PRINTED NAME DATE

_____ _____
PATIENT SIGNATURE PEDIATRIC ASSOCIATES WITNESS

Patient Cell Number: _____

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

Effective June 6, 2017