OVER 18 HIPAA RELEASE and CONSENT

Patient Responsibility Agreement

Patient Name: _____ DOB: _____

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 written specific permission. **Complete Pediatrics, P.C.** will not speak with my parents, permit my parents to schedule appointments, or provide medical information to my parents unless in accordance with this document.

I wish to grant my parents and/or guardians access to my healthcare providers and/or medical information as follows: (YOU MUST SELECT ONLY ONE OPTION AND INITIAL)

PLEASE PRINT THE NAME(S) OF THOSE WHO MAY ACT ON YOUR BEHALF

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

____ 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 **Complete Pediatrics, P.C.** to schedule appointments, discuss my healthcare and access my medical records. **THEY HAVE NO RESTRICTIONS. I DO GRANT ACCESS TO MY MEDICAL RECORDS.**

___ I DO NOT give the above named individual(s) permission to contact or speak with any physician or member of the staff at **Complete Pediatrics, P.C.** to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS.**

My signature here means I have read this information and understand it. This consent is valid until revoked in writing. I understand that I can revoke my consent at any time.

Patient Name _____ **Signature** _____ **Date** _____

COPE, P.C. Witness _____ **Signature** _____ **Date** _____