Alger Pediatrics 18+ privacy and release of information form

**Please note: this form must be completed and signed by the patient.*

Patient's name: _____ **Patient's date of birth:** _____

I understand and acknowledge that as of my 18th birthday, my parent/guardian will no longer be permitted access to my medical records and information without my specific written permission.

Alger Pediatrics will not release any medical information to my parent/guardian or permit my parent/guardian to schedule appointments without my written consent in accordance with this document.

☐ I do not wish to grant a third party access to my medical information. Alger Pediatrics will share medical information only with me, the patient.

☐ I wish to grant the below person(s) access to some or all of my medical information.

Name: _____

Relationship: _____

Phone number: _____

I wish to grant the person(s) named above access to the following medical information:

☐ All medical information, including all records listed below.

- ☐ Office notes
- ☐ Lab results; pathology reports
- ☐ X-rays
- ☐ Financial history report
- ☐ Nursing home, home health, hospice, and other physician records
- ☐ Mental health records
- ☐ Record of communicable disease testing (including HIV)
- ☐ Alcohol/drug abuse treatment
- ☐ Only share the following information:

  _____

This authorization is valid for one year from the date signed, unless an earlier termination date is specified. This authorization may be revoked in writing at any time. Alger Pediatrics does not require this authorization as a condition for the delivery of healthcare or treatment. There is potential that information disclosed in this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA).

Patient signature: _____ **Date signed:** _____