Over 18 HIPAA Release and Consent Form
Acknowledgement of Receipt of Privacy Practices.

Patient Name: _____ Date of Birth __/__/____

I understand and acknowledge that as of my eighteenth (18) 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. Northwest Hills Pediatrics will not speak with my parents, or release medical information to my parents without my written consent in accordance with this form.

☐ I WISH TO grant my parents and/or guardian access to my healthcare providers and/or medical information as follows:

_____ _____
Print Name of Parents or Guardians Relationship to you

☐ I give the above-named individual(s) permission to act on my behalf with NO limitations, including sexual and mental health and substance use history. I understand that they may contact any provider or member of staff at Northwest Hills Pediatrics to discuss my healthcare and access my complete medical records.
THEY HAVE NO RESTRICTIONS.

☐ I give the above-named individual(s) permission to act on my behalf with limitations, please check appropriate boxes: ☐ sexual health ☐ mental health ☐ substance use history. I understand that they may contact any provider or member of the staff at Northwest Hills Pediatrics to discuss my healthcare and access my complete medical records**.**
THEY HAVE SOME RESTRICTIONS

☐ I give the above-named individual (s) permission to contact and speak with any provider or member of the staff at Northwest Hills Pediatrics for the sole purpose of scheduling appointments. NO access to my medical record or information regarding my care can be discussed or provided.
APPOINTMENT ACCESS ONLY

☐ I give the above-named individual(s) permission to request refills

☐ I **DO NOT** grant any access to my parents and / or guardians. No medical information records can be discussed or released.

This content if valid from date signed. I understand that I can withdraw this consent at any time in writing.

Patient Signature_____ Date: ____/____/_____

Over 18 Communication Authorization Request
And Patient Record of Disclosures

Patient Name: _____ Date of Birth __/__/_____

I wish to be contacted in the following method. (Please check all that apply)

☐ Cellphone Number: (____) _____-_____

☐ OK to leave a message ☐ Brief ☐ Detailed

☐ DO NOT leave a message

☐ Home Telephone Number: (_____) _____-_____

☐ OK to leave a message ☐ Brief ☐ Detailed

☐ DO NOT leave a message

☐ Email: _____

Patient Signature: _____ Date ___/___/_____