Summit Pediatrics
And
Adolescent Medicine

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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. Summit Pediatrics 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 guardian(s). No medical information, records or appointment information can be discussed or released.

____ I WISH TO grant my guardian(s) access 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.)

_____ 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 SP to schedule appointments, discuss my healthcare, and access my complete medical records including request refills and pick up my prescriptions. THEY HAVE NO RESTRICTIONS.

_____ I give the above named-individual(s) permission to contact and speak with any physician or member of the staff at SP for the sole purpose of scheduling an appointment. NO access to my medical record or information regarding my care can be discussed or provided. APPOINTMENT ACCESS ONLY.

Signature: _____ Date: _____

Print Name: _____

This consent is valid until I personally withdraw it. I understand that I can withdraw consent at any time by providing Summit Pediatrics with written notice indicating the changes in access.