Health Information Management
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pediatrics NORTHWEST PS
Mary Bridge Children's

OVER 18 HIPAA 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, healthcare information, providers, and or appointment status without my specific written permission. Pediatrics Northwest 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 parent and/or guardian. No medical information, records, or appointment information can be discussed or released.

☐ **I DO** grant my parent and/or guardian access to my healthcare providers and/or medical information as follows (please print name of parent or guardian to whom you want to grant access):

Name:_____ Relation to Patient: _____

Name:_____ Relation to Patient: _____

If you choose to grant your parent and/or guardian access, please choose ONE of the following options:

☐ 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 Pediatrics Northwest staff to schedule appointments, request prescriptions and discuss my healthcare. **THEY HAVE NO RESTRICTIONS.**

(This permission does not include discussion of my mental health, sexual health, or any drug or alcohol abuse issues. Per federal and state law, Pediatrics Northwest may not discuss these topics without my separate explicit permission)

☐ I give the above-named individual(s) permission to contact and speak with any physician or member of Pediatrics Northwest staff regarding scheduling an appointment, refill requests, and/or picking up my prescriptions. **APPOINTMENT AND PRESCRIPTION ACCESS ONLY.**

☐ I give the above-named individual(s) permission to contact and speak with any physician or member of Pediatrics Northwest staff for the sole purpose of scheduling, rescheduling or confirming an appointment. No information regarding my care can be discussed or provided. **APPOINTMENT ACCESS ONLY.**

_____ _____

Patient Printed Name Date

_____

Patient Signature

This consent is valid for three years from the date signed. I understand that I can withdraw consent at any time by providing Pediatrics Northwest with a written letter requesting a change in access or filling out a revocation form.