PATIENT OVER 18 yoa HIPAA RELEASE & CONSENT FORM

I understand and acknowledge that as of my 18th birthday, I am ultimately responsible for my own healthcare. 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. Upper Valley Pediatrics will not speak with my parents and/or guardian, permit my parents and/or guardian to schedule appointments, request prescriptions, or release any medical information without my written consent in accordance with this document. Upper Valley Pediatrics, unlike other medical facilities, will answer questions regarding bills and/or accept payments on account from a parent and/or guardian given that they are specifically listed as the billing responsible party. I understand that UVP will continue to make appointment reminder calls/leave messages to the phone numbers linked to my account. No health information is provided in these calls.

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

_____ I AUTHORIZE my parent and/or guardian access to my healthcare providers and/or medical information as follows:

_____
(Print Name of parent or guardian, indicate his/her relationship to you)

_____
(Print Name of additional authorized individual, indicate 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 UVP to schedule appointments, discuss my healthcare, request prescription refills, and access my medical information. THEY HAVE NO RESTRICTIONS.

_____ I give the above named-individual(s) permission to contact and speak with UVP 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 SCHEDULING ACCESS ONLY.**

_____ I give the above-named individual(s) permission to contact and speak with UVP for ***the sole purpose of requesting prescription refills.*** **NO** access to my medical record or information regarding my care can be discussed or provided.

_____ I give the above-named individual(s) permission to contact and speak with UVP ***with the following limitations:*** _____
(i.e.: no disclosure of contraception / STD / Substance abuse related information)

I understand that I can withdraw/revise consent at any time by providing WRITTEN NOTICE to UVP and this authorization remains in effect until I revoke/revise it.

_____ _____
Patient's Printed name Date

_____
Patient's Signature