CONSENT TO DISCUSS MEDICAL INFORMATION AND PROTECTED HEALTH INFORMATION OF A PATIENT OVER 18 YEARS

Patient Name (please print): _____ Date of Birth: _____
First, M.I., Last Name

I authorize Watchung Pediatrics and its staff to discuss my medical information as follows (initial below all that apply):

- For financial purposes, I allow my parent(s) to access to my diagnosis and treatment information and to discuss my account: _____
- I allow my immunization records to be released by fax or mail to: _____ **school** _____ **parents**
- I allow my treatment plans (i.e.: medication, asthma, epi-pens, etc.) to be disclosed to: _____ **school** _____ **parents**
- I allow my office visits to be accessed by: _____ **school** _____**parents**
- I allow my labs to be released to: _____**school** _____**parents**
- With my prior consent, I allow any "confidential information" to be shared with: _____ **school** _____ **parents**
- I allow my parent to have access to my online medical records. I understand that I cannot limit access to my online records. _____ **yes** **or** _____**no**
- Other: _____

_____
Parent/Guardian 1 Relationship

_____
Parent/Guardian 2 Relationship

_____
Name of School

I am requesting online access to my medical records. The email address to send my registration is _____

I understand that I am financially responsible for all charges unless my parents agree, in writing, to continue financial responsibility. _____
(Initials)

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____
Signature **Date**

I understand that I may revoke this consent at any time and I must notify Watchung Pediatrics in order to revoke the consent.

_____
(Signature of patient) (date signed)

_____ _____
(Printed name of signature above) (phone number)

REVOKE CONSENT

(do not sign below unless you are revoking the above consent)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

_____
(Signature of patient) (Date signed) *Revised 7.2017*