Patient Responsibility Agreement

Over 18 HIPAA Release and Consent

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. West End Pediatrics will not speak with my parents, permit my parents to schedule appointments or provide medical information to my parents unless in accordance with this document.

I wish to grant my parents and/or guardians access to my healthcare providers and/or medical information as follows: PRINT THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF

THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS THIS SECTION IS CHECKED OFF AND SIGNED

Yes/No	Yes/No	Yes/No
Psychiatric Records ☐/☐	Sexual Records ☐/☐	Drug & Alcohol Records ☐/☐

_____
(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

_____
(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

• I understand that if the person or the entity that receives this information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

• I understand that there may be medical records from another doctor or another medical facility in my chart.

• I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for treatment.

• I understand I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

This consent is valid for one (1) year from the date signed. I understand that I can withdraw consent at any time by providing West End Pediatrics with a written consent indicating the changes in access.

_____ _____
PATIENT NAME (Print Legibly) Date

_____
PATIENT SIGNATURE

_____ _____
WEST END PEDIATRICS WITNESS Date