Authorization To Release Medical Records

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. Pediatrics at Whitlock 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 any individual. No medical information, records or appointment information can be discussed or released.

_____ **I WISH TO** grant access to my medical information to:

_____

(Print Name of the individual; indicate his/her relationship to you.)

_____

(Print Name of second individual; indicate his/her relationship to you.)

Check All That Apply:

_____ 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 Pediatrics at Whitlock to schedule appointments, discuss my health care, and access my complete medical records. **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 Pediatrics at Whitlock 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.**

_____ I give the above named-individual(s) permission to contact and speak with any physician or member of the staff at Pediatrics at Whitlock for results regarding any labs or procedures.

_____ _____

PATIENT PRINTED NAME DATE

_____ _____

PATIENT SIGNATURE OFFICE WITNESS