Young Adult Consent Form

Authorization to Release Protected Health Information (PHI)

This form is used to allow your parents or anyone else you choose to have access to your medical information.

Patient's Legal Name: ____ Patient's Date of Birth: ____/_____/___________

Patient's Phone Number: ______________________________ Patient's Email: ____

As an adult, your medical records are private information thatis kept strictly between you and your health care provider under the federal Health Information Portability and Accountability Act (HIPAA). Access to your health records and any discussion about your health is only provided to people you consentto. **If you would like your parents, or someone else, to discuss your health on your behalf, you must provide consentto your health care provider.**

I authorize/give permission to Dover Pediatrics, PLLC to discuss my GENERAL health information and SENSITIVE health information only as indicated below with the following individual(s): *a separate form can be requested to give different permissions to differentindividuals*

NAME (first and last):	RELATIONSHIP TO YOU:	PHONE NUMBER:

Sensitive Health Information to be Released/Discussed:

IMPORTANT! Itis extremely importantthat you check DO or DO NOT for each item listed below. Please do not skip any item as it could impact our ability to fulfill your request.

I DO DO NOT want **appointments made/cancelled** on my behalf.

I DO DO NOT want **health forms** and **immunization records** released.

I DO DO NOT want my **gender identity** discussed.

I DO DO NOT want **sexual orientation** discussed.

I DO DO NOT want detailed **behavioral/mental health** records discussed.

I DO DO NOT want detailed **sexually transmitted diseases/HIV/AIDS** records discussed.

I DO DO NOT want detailed **alcohol/substance use** records discussed.

I DO DO NOT want detailed **sexual health/history** records discussed.

I DO DO NOT want detailed **birth control** records discussed.

I DO DO NOT want detailed **pregnancy** records discussed.

I DO DO NOT want **(specify)** ____ discussed/disclosed.

I understand this authorization is valid for ONE YEAR and may be revoked (withdrawn) at any time prior to the expiration date by notifying the practice in writing, exceptto the extentthat Dover Pediatrics, PLLC has already used or disclosed the information in reliance on my authorization.

Patient's Signature Date