WESTSIDE PEDIATRICS

Michael N. Yaker, M.D.
Victoria Dixon Dahms, M.D.
Debbie Horn, M.D.
Lia M. Album, CPNP

Adrianne Goldberg, M.D.
Amy DeMattia, M.D., MPH
Christina Madhany, M.D.
Suzanne Bussetti, CPNP, IBCLC

Over 18 HIPAA Release and Consent Form

Patient Name (Print): _____ Date of Birth: _____

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. Westside Pediatrics 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 WISH TO** grant my parents and/or guardian access to my healthcare providers and/or medical information as follows:

_____ _____
Print Name of parent or guardian Relationship to you

_____ _____
Print Name of second parent or guardian Relationship to you

☐ I give the above-named individual(s) permission to act on my behalf with **NO** limitations, including sexual and mental health and substance use history. I understand that they may contact any physician or member of the staff at Westside Pediatrics to schedule appointments, discuss my healthcare and access my complete medical records.
THEY HAVE NO RESTRICTIONS.

☐ I give the above-named individual(s) permission to act on my behalf with limitations, please check appropriate boxes**: □sexual health □mental health □substance use history**. I understand that they may contact any physician or member of the staff at Westside Pediatrics to schedule appointments, discuss my healthcare and access my complete medical records.
THEY HAVE SOME RESTRICTIONS.

☐ I give the above named-individual(s) permission to contact and speak with any physician or member of the staff at Westside Pediatrics 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 **request refills and pick up my prescriptions**.

☐ I **DO NOT** grant any access to my parents and/or guardians. **No medical information records or appointment information can be discussed or released**.

This consent if valid from the date signed. I understand that I can withdraw this consent at any time in writing.

Patient Signature: _____ Today's Date: _____

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OVER 18 COMMUNICATION AUTHORIZATION REQUEST

AND PATIENT RECORD OF DISCLOSURES

Patient Name (Print): _____ Date of Birth: _____

I wish to be contacted in the following manner: (*please check all that apply)*

❑ **Mobile Telephone**: _____

- ❑ OK to leave a message with call back number
- ❑ DO NOT leave a message

❑ **Home Telephone**: _____

- ❑ OK to leave a message with call back number
- ❑ DO NOT leave a message

❑ **Written Communications:**

- ❑ OK to email me: _____
- ❑ OK to fax me (home only): _____

Patient Signature: _____ Today's Date: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records of PHI disclosure.