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, or appointment status without my written permission. North Florida 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.

_____

(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

_____

(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

_____I give the above-named permission to act on my behalf **with no limitations.** I understand that they may contact any provider or member of the staff at North Florida Pediatrics to schedule appointments, discuss my healthcare and access my medical records.

_____I **DO NOT** grant access to my parent(s) or guardians for medical information, records, appointment requests/status. No information may be release without my written consent.

_____

PATIENT NAME (Print Legibly) **Date** **PATIENT SIGNATURE**