GROW Pediatrics & Adolescent Medicine, PLLC
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PATIENT HIPAA CONSENT AND RELEASE

I understand and acknowledge that as of my 16th 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. GROW Pediatrics will not release medical information to my parents without my written consent in accordance with this document.

I understand that I can withdraw consent at any time by providing GROW Pediatrics with written notice indicating the changes in access.

INITIAL

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

INITIAL

I **AUTHORIZE** the listed individuals access to my healthcare providers and/or medical information with the indicated restrictions.

Authorized Individual	Relationship to Patient	Restrictions (Disclosure Not Allowed)
		☐ Drug/Alcohol abuse ☐ Reproductive Care/Sexual Health ☐ Mental Health ☐ STD /HIV/AIDS testing ☐ Other:
		☐ Drug/Alcohol abuse ☐ Reproductive Care/Sexual Health ☐ Mental Health ☐ STD /HIV/AIDS testing ☐ Other:
		☐ Drug/Alcohol abuse ☐ Reproductive Care/Sexual Health ☐ Mental Health ☐ STD /HIV/AIDS testing ☐ Other:

PATIENT'S CELL NUMBER

_____ - _____ - _____

SIGNATURE OF PATIENT

Signature of Patient _____ Date _____

Printed Name of Patient _____ Date of Birth _____