18 + PHI Release

Authorization to release protected health information to parents/guardians of adult children.

I, _____, a patient of GROW Pediatrics and Adolescent Medicine, understand my rights as a legal adult for my health information to be kept confidential and not shared with any individual other than myself. This includes conversations with my physician, diagnostic testing and results, appointment details, and anything else related to my care at GROW. My signature here indicates that I;

☐ **DO give permission** for my parents/guardians to continue to access my PHI.

Print parent/guardian name(s) here:_____

☐ **Do NOT give permission** for my parents/guardians to continue to access my PHI.

_____ _____

Patient Signature & Date of Birth **Date Signed**