ARLINGTON PEDIATRIC ASSOCIATES, PC

5 Water Street, Arlington, MA 02476 **Phone: 781-641-5800** **Fax: 339-707-6028**

Over 18 HIPAA Release and Consent Form

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. Arlington Pediatric Associates (APA) 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 DO NOT** grant any access to my parents and/or guardians. No medical information, records or appointment information can be discussed or released.

_______**I WISH TO** grant my parents and/or guardian access to my healthcare providers and/or medical information as follows:

____

(Print the name of the parent or guardian; indicate their relationship to you)

____

(Print the name of the parent or guardian; indicate their relationship to you)

I give the above-named individual(s) permission to act on my behalf. I understand that they may contact any physician or member of the staff at APA to schedule appointments, discuss my healthcare, and access to the following portions of my medical records.

Check Boxes to give Medical Record Access to above-named individual

- ○ Entire Medical Record
- ○ Drug Alcohol Substance Abuse Records
- ○ Mental Health Records (Except Psychotherapy notes)
- ○ HIV/AIDS-Related Information (including test results)
- ○ Sexually Transmitted Disease Records (including test results)
- ○ Genetic Information (including Genetic Test Results)

_______I give the above-named individual(s) permission to contact and speak with any physician or member of the staff at APA 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.

________________________________ PATIENT PRINTED NAME

________________________________ Patient Signature ______________________ APA Witness

This consent is valid for one year from the date signed. I understand that I can withdraw consent at any time by providing Arlington Pediatric Associates with written notice indicating the changes in access.

Effective Date:________________