 Town Pediatrics 

Adolescent Consent, Disclosure and Authorization Letter and Form

Dear Patient:

As you approach adulthood, you may have visits with us where you disclose sensitive information. This sensitive information, if you are under age 18, is your information. Additionally, when you reach your 18th birthday, and become a legal adult, please understand that your parents or legal guardians are no longer considered your legal representatives. Under state law and federal HIPAA regulations, you can consent to your own medical care and control your own medical records and information. This means that, with certain limited exceptions, we can no longer share your records or any medical information about you with your parents, or anyone else, without your written permission.

We do encourage you to continue to discuss, whenever possible, any health problems or concerns with your parents or legal guardians and to continue to seek their advice. If you would like us to be able to share your information with your parents, legal guardians, or anyone else, we ask you to fill out and sign the enclosed Consent, Disclosure and Authorization form. Note that you can specify with whom we can share your information, and the type of information we may share. You are welcome, of course, to bring your parents or guardians with you when you visit us in the office.

You are welcome to manage your own medical care and can authorize a parent/guardian to have access to your personal information if you wish. If you choose to give authorization to a parent/guardian, please be aware that you must fully complete all sections on the attached consent form AND consent to release all information (in Section 3) for your parent/guardian to be able to speak on your behalf or to receive information from your medical record.

Please complete and sign the attached authorization forms and return it to us prior to your 18th birthday if you have disclosed sensitive information to us, or soon after you celebrate your 18th birthday.

Please let us know if you have any questions or concerns about completing this form.

Thank you.

The Providers at Town Pediatrics

Town Pediatrics

Adolescent, Consent Disclosure and Authorization Form

Section 1

Patient Name: _____ DOB: _____

Section 2

Person/entity authorized to receive information (verbally/in writing)

Name of person: _____
Relationship: _____
Name of entity: _____
Telephone number: _____ Fax # _____

Section 3

I hearby authorize the release of the followin to the person listed above: (check all that apply) For release of sensitive information under age 18 and for patients age 18+. All sections must be checked off for Town Pediatrics to speak with other individuals. Partial completion of the form is not allowed.

☐ History/physical exams	☐ Appointment and visit notes	☐ Lab & X ray reports
☐ Consultation notes	☐ Prescriptions	☐ Mental Health Records
☐ Alcohol/Drug abuse	☐ HIV/Aids testing & related info	☐ Sensitive info including STD's

Section 4

By signing this authorization, I authorize Town Pediatrics to disclose any information, including protected health information, they have about me. An Authorization remains valid for ***two years*** unless an expiration date is identified or the authorization is revoked in writing by the individual before that date.

Specific Time period: _____ Date: _____
Patient signature: _____ Date: _____
Parent/Guardian signature*_____ Date: _____
*(not needed for sinsitive information/18+ parental involment in care)