

# Permission to Release Medical Information

18 years and Older, Married or Pregnant and under 18 years of age, Emancipated Minor, Certified Homeless

Under the federal Health Information Portability and Accountability Act, or HIPAA, medical records are private information that is kept between you and your health care provider. Access to your health records and any discussion about your health is only provided to people you consent to, **including your parents**. This form will allow your **parents** or anyone else that you have identified access to your medical information.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please list the person(s) that you are allowing access to your medical information:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

### **Important Information**

**Please note that if your parent still maintain healthcare coverage for you, they may have access to billed procedures, including but not limited to office visits, lab tests (including pregnancy, HIV, and tests for sexually transmitted diseases) or other procedures.**

I authorize Pediatric Health Care Alliance to release the following information (check all that apply):

- Access to all medical records **excluding** diagnosis for mental health, HIV, other STD, or pregnancy
- Access to all medical records **including** diagnosis for mental health, HIV, other STD, or pregnancy\*
- Discuss my care with my Pediatric Health Care Alliance provider.
- Schedule or inquire about scheduled appointments (well, sick or consultations).
- X-Ray or other radiology reports
- Laboratory results (including HIV or other STD results)\*
- Pharmacy/ Prescription records\*
- Other (describe specifically) \_\_\_\_\_

**\*Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

**This form does not expire: In the event I would like to append my authorization, it is my responsibility to update this information.**

I, \_\_\_\_\_ (please print), authorize the above listed person(s) access to my medical information (specific approval access above).

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_