

18 years and Older Release Form

Description of "Protected Health Information" to be Used or Disclosed

Patients Name (Print): _____ **Date of Birth:** _____

I understand that it is the policy of ANDERSON HILLS PEDIATRIC'S, INC. (the "Practice") to protect my privacy and to follow all state and federal privacy laws. However, I also understand that in order to **allow my parents to assist in my medical care** it will be necessary for the Practice to use/disclose some of my medical information ("Protected Health Information"), and, specifically, **health issues I encounter while under the care of this practice**. I understand that my Protected Health Information to be disclosed may include information regarding genetic testing, HIV / AIDS status, mental health diagnosis and treatment and substance abuse diagnosis and treatment, and I hereby specifically authorize the Practice to disclose such sensitive information to the persons listed below.

My Protected Health Information will be used / disclosed by the doctors, or the clinical and administrative staff of the Practice, for the purposes described above.

Child's Rights

I understand that I have the right to refuse to sign the Authorization to release my Protected Health Information. If I refuse to sign this Authorization, the Practice will in no way deny me my rights concerning treatment, payment for services, and enrollment in a health plan or eligibility for benefits.

I understand that I may revoke this Authorization at any time after I have signed it by providing Brian Vanderhorst, the Practice Manager, and the Practice's Privacy Officer, with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my Protected Health Information can no longer be used / disclosed pursuant to this Authorization except when **medically necessary**.

I specifically authorize this disclosure of my Protected Health Information as set forth in this Authorization. I understand that if my Protected Health Information is disclosed, then this information may be subject to re-disclosure by the recipient and may no longer be protected by the federal patient privacy laws.

This Authorization, unless I earlier revoke it, shall remain in effect for **as long as I am an active patient at this practice**.

Patient's Signature

Form Received - Refuse to Disclose Medical Records _____ (initial)

Check Disclosure below ONLY if Patient is a Minor

<p>If this Authorization is signed by a legal representative of the patient (for example, the parent or legal guardian if the patient is a minor) a description of such representative's authority to act for the patient must also be provided (check applicable box and/or explain your authority to sign for the patient below). Except for legal representatives acting in the capacity as a parent to the patient, also attach a copy of documentation giving you the authority to sign this Authorization on behalf of the patient.</p>	
<p>_____ Parent</p> <p>_____ Guardian</p> <p>_____ Power of Attorney</p>	<p>_____ Health Care Proxy or Surrogate</p> <p>_____ Executor or Administrator of Estate of Patient</p>
<p>Note: A copy of this signed Authorization must be provided to the individual signing the document.</p>	