Over 18 HIPAA 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 without my written permission.

_____ I **do not** give permission to my parents and /or guardians. **No medical information can be discussed or released.**

_____ I give permission to my parents and/or guardians to access my medical information. I understand that they may contact Concord Children's Clinic to discuss my healthcare, and access my complete medical records.

_____

Print the name of the parent or guardian; indicate his/her relationship to you.

_____

Print the name of the second parent or guardian; indicate his/her relationship to you.

_____ _____

Print Patient's Name Date

_____ _____

Patient Signature Concord Children's Clinic Witness

This consent is valid for 1 year from the date signed. I understand that I can withdraw the consent at any time by providing Concord Children's Clinic with a written notice indicating the change in access.

Effective Date: