Concord Children's Clinic
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www.ConcordChildrensClinic.com

PATIENTS 18 +
HIPPA Consent Form

Patient Name _____ Date of Birth _____ *MR # (clinic staff only)* _____

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.
(Please provide your information for communication below)

Phone Number _____ E-Mail Address _____

☐ I give permission to my parents and/or guardians (as listed below) to access my medical information. I understand that they may contact Concord Children's Clinic to discuss my healthcare and access my complete records.
(Prevention, diagnosis, & treatment of: STI, Substance Abuse, Pregnancy, Emotional Disturbance information may be marked as confidential)

Patient Phone Number _____ Patient E-Mail Address _____

Printed name of parent / guardian _____ Relationship to patient _____

Printed name of 2nd parent / guardian _____ Relationship to patient _____

Authorization for Release of PHI (Protected Health Information)

Your PHI included general health information, laboratory tests and billing information.

Is it OK to contact you by phone and/or leave you a detailed message in your voice mail? (circle one)

YES	NO
☐	☐

Is It OK to leave detailed messages with anyone other than yourself (ex: spouse, partner, parents, please provide their name and phone number.

Name of Person _____ (Phone #) _____

I understand that I have the right to revoke this HIPPA & PHI authorization at any time by providing a new copy of this form to the clinic. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be condition.

I have reviewed and understand the HIPPA Statement & PHI information stated above.

Patient Signature _____ Concord Children's Clinic Witness _____