Boston Children's Health Physicians
New York & Connecticut

Over 18 HIPAA Release and Consent form

Except as I otherwise authorized below, as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Boston Children's Health Physicians, LLP ("BCHP") will not permit my parents to schedule appointments or release medical information to my parents without my written consent in accordance with this document.

_____ **I WISH TO** grant my parents and/or guardians access to my healthcare providers and/or medical information as follows:

_____

(Print name of parent or guardian; indicate his /her relationship to you)

_____

(Print name of Second parent or guardian; indicate his/her relationship to you)

_____ I give the above-named individual(s) permission to act on my behalf. I understand that they may contact any physician or member of the staff at BCHP to schedule appointments, discuss my healthcare, request prescription refills, and access my complete medical records.

Please specify if you wish to include the following (*Indicate by initialing*):

_____Alcohol/Drug Treatment
_____Mental Health Information
_____HIV-Related Information

_____ I give the above-named individual(s) permission to contact and speak to any physician or member of the staff at BCHP for *the sole purpose of scheduling an appointment*. NO access to my medical record or information regarding my care can be discussed or provided.

I acknowledge and agree that:

1. I do not have to sign this authorization and signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

2. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

3. I have the right to revoke this authorization at any time with a written notice to BCHP indicating the changes in access, except to the extent that BCHP has acted in reliance upon it.

4. This authorization is valid for one (1) year from the date signed, unless revoked by me prior to the end of this period.

_____ _____

Patient Printed Name Date

_____

Patient Signature