CONSENT TO DISCUSS MEDICAL INFORMATION AND PROTECTED HEALTH INFORMATION OF A PATIENT OVER 18 YEARS

Patient Name: _____ Date of Birth: _____

I authorize East Bay Pediatrics and its staff to discuss my medical information as follows (**initial below all that apply):**

- For financial purposes, I allow my parent(s) or legal guardian to access my diagnosis and treatment information and to discuss my account: _____
- I allow my immunization records to be released by fax, mail or patient portal to a parent or legal guardian: _____
- I allow my treatment plans (i.e: medication, asthma, epi-pens, etc.) to be disclosed to a parent or legal guardian: _____
- I allow my office visits to be accessed by a parent or legal guardian: _____
- I allow my labs to be released to a parent or legal guardian: _____
- I allow my parent or legal guardian to have access to my online medical records. I understand that I cannot limit access to my online records. Yes _____ No_____
- Other:
  _____

_____

Parent/Guardian Relationship

_____

Parent/Guardian Relationship

I am requesting online access to my medical records. The address to send my registration is_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another party. I hereby consent to such disclosure for these permitted uses.

I fully understand and accept the terms of this consent.

_____ _____

Signature **Date**

I understand that I may revoke this consent at any time and I must notify East Bay Pediatrics in order to revoke the consent.