

Health Information Access Authorization Form (18+)

Now that you are 18, you are legally an adult. This means all of your medical information is private, and we will only share it with people you give us permission to talk to. This form lets you tell us what kind of access (if any) you want your parent(s), guardian(s), or others to have.

The following types of information may be shared if you give permission:

- Appointments, test results, medications, allergies, immunizations, preventive care, medical history, hospital visits, billing information, messages, and letters.
- Sensitive information such as mental health, substance use, or STD testing and treatment may be included.

Access Options

- I want my Authorized Representative(s) to have full access to my health information. This includes appointments, test results, messages, billing, and medications.
- I only want my Authorized Representative(s) to have limited access. Please list what they can access (e.g., billing only): _____
- I do not want anyone else to have access to my medical information unless I tell you otherwise.

You can change your mind at any time by submitting a signed letter to us. This authorization is voluntary and does not affect your care. It will remain valid until you revoke it in writing.

Authorized Representative Information

Name:	Phone #:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Acknowledgment

I authorize MD Pediatric Associates to grant my designated authorized representative identified above ("Authorized Representative) access to portions of my ePHI, including clinical and billing information, maintained through MD Pediatric Associates.

Patient's Printed Name: _____ DOB: _____

Patient's Signature: _____ Today's Date: _____

Patient's Personal Email: _____ Phone #: _____

