

## OVER 18 YEARS OF AGE AUTHORIZATION TO RELEASE INFORMATION

I, (print name) \_\_\_\_\_, understand as a patient age 18 or older that my medical information will no longer automatically be shared with my parents. I acknowledge that I must give authorization to the providers and staff at Village Pediatrics to discuss my medical care and concerns with anyone other than myself.

CONFIDENTIAL INFORMATION WILL NOT BE DISCUSSED WITH ANYBODY (regardless of the box checked below) unless it is required by law. Confidential information includes mental health, substance abuse, sexual health, sexually transmitted infection/AIDS/HIV testing and results.

I **give** authorization to the providers at Village Pediatrics to discuss my medical information with the people listed below:

Authorized Person Name	Relationship	Phone Number

Village Pediatrics **can** share with them:

- All information
- Only non-sensitive information (lab results, medications, appointments)

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*This section must be completed and is not related to the above information*

**In the event of an emergency, I give Village Pediatrics consent to notify:**

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

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*I fully understand and accept the terms of this consent. I understand that I may revoke this consent at any time, and that I must notify Village Pediatrics in writing.*

PATIENT SIGNATURE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

PATIENT PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_