AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name: ____ Patient DOB: ______________________________

Patient Phone Number: __________________________________ Patient Email: _____________________________

Patient Address: ____

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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, information, providers or appointment status without my specific written permission.

I give the below-named individuals(s) permission to act on my behalf with NO limitations, including sexual and mental health and substance use history. I understand that they may contact any physician or member of the staff at Palmetto Pediatrics of the Lowcountry to schedule appointments, discuss my healthcare/financial/insurance details, and access my complete medical records. THEY HAVE NO RESTRICTIONS.

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Name Relationship Phone Number

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Name Relationship Phone Number

☐ I do not want anyone other than myself to have access to my medical records, information, providers or appointment status. I understand that by checking this box that I will be the only person permitted to the above information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Palmetto Pediatrics of the Lowcountry. I understand that the revocation will not apply to information that has already been released in response to this authorization.

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Patient Signature Date Signed