Patient Responsibility Agreement
Over 18 HIPAA Release and Consent

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. Dawson Pediatrics will not speak with my parents, permit my parents to schedule appointments or provide medical information to my parents unless 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 THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF AND INITIAL THE PERMISSION GRANTED FOLLOWING. **(You must select only ONE option and initial)**

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(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

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(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

_______ I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any provider or member of the staff at Dawson Pediatrics to schedule appointments, discuss my healthcare and access my medical records. **THEY HAVE NO RESTRICTIONS**.

_______ I **DO NOT** grant access to my parent(s) or guardians for medical information, records, or appointment request/status. No information may be released without my written consent.

This consent is valid for one (1) year from the date signed. I understand that I can withdraw consent at any time by providing Dawson Pediatrics with a written consent indicating the changes in access.

_____________________________________ _____________________

PATIENT NAME (Print Legibly) **DATE**

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PATIENT SIGNATURE