The Pediatric Care Center, LLC

18 & Over HIPAA Release and Authorization Form

Patient Name: _____ Date of Birth: _____

Authorization to Release Information

I understand that as of my 18th birthday, my medical records and protected health information (PHI) are legally private. Healthcare providers cannot disclose this information to my parents, guardians, or third parties without my written permission.
By signing this form, I voluntarily grant permission for my healthcare provider to disclose my medical information to the following individuals:

Authorized Individual 1: _____ Relationship: _____
Authorized Individual 2: _____ Relationship: _____

Scope of Authorization (Select and initial ONE option below):
___ NO RESTRICTIONS: The above-named individual(s) may act on my behalf without limitations. They may contact any provider to discuss my healthcare, schedule appointments, access my complete medical records, and pick up prescriptions.

___ APPOINTMENT AND PRESCRIPTION ACCESS ONLY: The above-named individual(s) may only schedule or cancel appointments, request prescription refills, and pick up my medications. They MAY NOT access or discuss my medical records or clinical notes.

___ DO NOT GRANT ACCESS: I do not grant any access to my parents, guardians, or any other third parties. No medical information, records, or appointment details can be discussed or released.

Expiration and Revocation
This authorization will remain valid for one year from the date of my signature OR until the following date: _____.

- Revocation: I understand I can revoke this consent at any time by providing written notice to my healthcare provider.
- Re-disclosure: I understand that information disclosed under this authorization might be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

Patient Consent

I acknowledge that signing this authorization is voluntary and my refusal will not affect my ability to obtain treatment or payment. The purpose is provided above so I can make a decision as the whether to allow the release of information.
I do not have to sign the authorization in order to receive treatment.
When my information is used or disclosed pursuant to this authorization, It may be subject to redisclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule or other law protecting its confidentiality. I have a right to revoke this authorization in writing, except where the office has acted in reliance upon it. My written revocation must be submitted to : Privacy Officer, The Pediatric Care Center, 1301 Farmington Ave, Bristol, CT 06010 or to the Privacy officer of the facility that is releasing information. This form may be deemed INVALID if all sections are not completed.

Patient Signature: _____ Date: _____
Printed Name: _____ Email: _____