BAER PEDIATRICS

Patient Responsibility Agreement

Over 18 HIPPA 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, or providers without my specific written permission. Baer Pediatrics will not speak with my parents/guardians or provide medical information to them 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: **(You must select only ONE option and initial)**.

PRINT THE NAMES BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF

(PRINT NAME OF PARENT AND/OR GUARDIAN, INDICATE RELATIONSHIP)

(PRINT NAME OF PARENT AND/OR GUARDIAN, INDICATE RELATIONSHIP)

_____ I GIVE THE ABOVE NAMES INDIVIDUAL(S) PERMISSION TO ACT ON MY BEHALF WITH NO LIMITATIONS. I UNDERSTAND THAT THEY MAY CONTACT ANY PHYSICIAN OR MEMBER OF THE STAFF AT BAER PEDIATRICS TO DISCUSS MY HEALTHCARE AND ACCESS MY MEDICAL RECORDS. **THEY HAVE NO RESTRICTIONS.**

_____ I GIVE THE ABOVE NAMES INDIVIDUAL(S) PERMISSION TO CONTACT AND SPEAK WITH ANY PHYSICIAN OR MEMBER OF THE STAFF AT BAER PEDIATRICS TO DISCUSS MY CARE AND SCHEDULE ANY NEEDED SERVICES OR APPOINTMENTS. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS.**

_____ **I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIANS. NO MEDICAL INFORMATION, RECORDS, OR APPOINTMENT INFORMATION CAN BE RELEASED.**

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

_____ _____

PATIENT NAME (Print Legibly) DATE

_____

PATIENT SIGNATURE

_____ _____

BAER PEDIATRICS WITNESS DATE