BLOOMFIELD PEDIATRIC CARE
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. Bloomfield Pediatric Care 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: **(You must select only ONE option and initial)**
PRINT THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF

_____
(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

(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 physician or member of the staff at Bloomfield Pediatric Care to schedule appointments, discuss my healthcare and access my medical records. **THEY HAVE NO RESTRICTIONS.**

_____ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Bloomfield Pediatric Care to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS.**

_____ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Bloomfield Pediatric Care for the sole purpose of scheduling an appointment. No access to my medical records or information regarding my care can be discussed or provided. **APPOINTMENT ONLY ACCESS.**

_____ I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIAN. 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 Bloomfield Pediatric Care with a written consent indicating the changes in access.

_____ _____
PATIENT NAME CELL# DATE WITNESS SIGNATURE

_____ _____
PATIENT SIGNATURE DATE