Adolescent Confidentiality / Release Form

Patient Name	Date of Birth	Cell phone #
Street Address	City	State Zip

As a legal adult, I understand that all information that I discuss with my physician will be strictly confidential and any communications from Child and Adolescent Health Specialists, PC will be discussed with me directly. I also understand, however, that I may wish to authorize Child and Adolescent Health Specialists, PC to speak with my parent(s) regarding specific issues related to my medical care.

I hereby authorize Child and Adolescent Health Specialists, PC to communicate or release the following information (check all that apply)

- ❑ Appointment scheduling
- ❑ Medication requests/refills
- ❑ Referrals
- ❑ Insurance/billing
- ❑ Medical care/treatment/lab results with the ***EXCLUSION*** of any reference to: (circle all that apply) drug/alcohol usage, venereal disease, abortion, genetic testing, HIV testing, AIDS diagnosis/treatment, mental health treatment, or other protected information (please specify) _____
- ❑ Full access to my patient portal

with the individual(s) listed below:

Name(s): _____

Relationship to patient: ❑ Parent(s) ❑ Other _____

Address: _____

Telephone #: _____

❑ I do **NOT** authorize Child and Adolescent Health Specialists, PC to discuss any issues, provide access to or release any information related to my medical care with my parent(s).

This authorization will expire upon written revocation or once I have left the practice of Child and Adolescent Health Specialists, PC.

I understand that I may revoke this consent at any time by signing the Revocation Statement below, however such revocation does not affect any actions taken by Child and Adolescent Health Specialists, PC before I signed the Revocation Statement.

Signature: _____ Date: _____

REVOCATION STATEMENT:

I revoke the above authorization as of the date listed below.

Signature: _____ Date: _____