

CRANFORD PEDIATRICS

CONSENT TO DISCUSS MEDICAL INFORMATION AND PROTECTED HEALTH INFORMATION OF A PATIENT OVER 18 YEARS.

Patient Name(Please print) _____ D.O.B: _____
First, M.I., Last

I authorize Cranford Pediatrics and its staff to discuss my medical information as follows (initial below all that apply):

- For financial purposes, I allow my parent(s) access to my diagnosis and treatment information and to discuss my account _____
- I allow my immunization records to be released by fax or mail to: _____ school _____ parents
- I allow my treatment plans(i.e.: medication,asthma,epi- pens,etc.) to be disclosed to: _____ school _____ parents
- I allow my office visits to be accessed by: _____ school _____ parents
- I allow my labs to be released to: _____ school _____ parents
- With my prior consent,I allow any 'confidential information' to be shared with: _____ school _____ parents
- Other: _____

Parent/Guardian 1 Relationship

Parent/Guardian 2 Relationship

Name of school

I understand that as part of this organizations treatment,payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

I fully understand and accept the terms of this consent.

Signature

Date

I understand that I may revoke this consent at any time and I must notify Cranford Pediatrics in order to revoke the consent.

(Signature of patient)

(Date signed)

(Printed name of signature above)

(phone number)

Revoke Consent

(do not sign below unless you are revoking the above consent)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

(Signature of patient)

(Date signed)