CRANFORD PEDIATRICS

CONSENT TO DISCUSS MEDICAL INFORMATION AND PROTECTED HEALTH INFOR MATION 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)

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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)