PEDIATRIC HEALTHCARE ASSOCIATES 615 6TH AVENUE ALTOONA, PA 16602 814-944-7383

OVER 18 HIPPA CONSENT FORM

I understand and acknowledge that as of my 18th birthday, my parents and/or guardian will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Pediatric Healthcare Associates will not speak with my parents, permit my parents to schedule appointments, request refills, pick up prescriptions, or parents, permit my parents to schedule appointments, request refills, pick up prescriptions, or release medical information without my written consent in accordance with this document.

I DO NOT grant any access to my p	parents and/or guardians. No	nedical information,
I DO NOT grant any access to my records or appointment information can be	pe discussed or released.	
records of appointment	:	
IDO grant my parents and/or guardize information as follows: WITH NO RESTR permission to act on my behalf with no limit physician or member of the staff at Pediatric discuss my healthcare, request refills, pick my records.	ations. I understand that they	may contact any
(Print Name of the parent and/or g		
PATIENT PRINTED NAME	DATE OF BIRTH	TODAY'S DATE
PATIENT SIGNATURE	PEDIATRIC HEALTH	CARE WITNESS
T J	nat I can withdraw consent at a	my time by providing

This consent does not expire. I understand that I can withdraw consent at any time by providing Pediatric Healthcare Associates with written notice indicating the change in access.