Altoona Office
615 6th Avenue, Altoona, PA 16602
Phone: +1 814-944-7383 · Fax: +1 814-944-7608

Roaring Spring Office
105 Hillcrest Drive, Roaring Spring, PA 16673
Phone: +1 814-224-2555 · Fax: +1 814-944-7608

Over 18 HIPAA 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 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 parents and/or guardians. No medical information, records or appointment information can be discussed or released.

I DO grant my parents and/or guardian access to my healthcare providers and/or medical information as follows: **WITH NO RESTRICTIONS.** 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 Pediatric Healthcare Associates to schedule appointments, discuss my healthcare, request refills, pick up prescriptions, and access my complete medical records.

_____

(Print name of the parent and/or guardian; indicate relationship to you)

_____

(Print name of the second parent and/or guardian; indicate relationship to you)

Patient Printed Name	**Date of Birth**	**Today's Date**

Patient Signature	**Pediatric Healthcare Witness**

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.