Drs. Black and Benton, P.S.C.

Over 18 HIPAA Release and Authorization Form

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or inquire about appointment status without my specific written permission. Black and Benton Pediatrics will not release medical information to my parents without my written authorization in accordance with this document.

_____**I DO NOT** grant any access to my parents and/or guardians. **No medical information, records, or appointment status information can be discussed or released. They may not request refills or pick up my prescriptions.**

_____**I WISH TO** grant my parents/and or guardians access to my healthcare providers and/or medical information as follows:

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

I give the above-named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any provider or staff member to discuss my healthcare, and to access my complete medical record. They may request refills and pick up my prescriptions. **THEY HAVE NO RESTRICTIONS.**

_____ _____
PATIENT PRINTED NAME D.O.B.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PATIENT CONTACT NUMBER WITNESS SIGNATURE

This consent is valid for one year from the date signed. I understand that I can withdraw consent at any time by providing Black and Benton Pediatrics with written notice indicating the changes in access.