Over 18 HIPAA Release and Consent Form

Patient Name:	Date of Birth:

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 appointment status without my specific written permission. CAAC will not speak with my parents, permit my parents to schedule appointments or release medical information to my parents without my written consent in accordance with this document.

□ I WISH TO grant my parents and or/ guardian access to my healthcare providers and / or medical information as follows:

Print Name of Parent or Guardian	Relationship to you

I give the above-named individuals(s) permission to act on my behalf with NO limitations, including sexual and mental health and substance use history. I understand that they may contact any physician or member of the staff at CAAC to schedule appointments, discuss my healthcare and access my complete medical records. **THEY HAVE NO RESTRICTIONS.**

I understand that they may contact any physician or member of the staff to schedule appointments, discuss my healthcare and access my complete medical records. **THEY HAVE SOME RESTRICTIONS.**

I give the above-named individuals(s) permission to contact and speak with any physician or member of the staff for the sole purpose of scheduling an appointment. NO access to my medical record or information regarding my care can be discussed or provided. **APPOINTMENT ACCESS ONLY.**

□ I give the above-named individual(s) permission to request refills and pick up my prescriptions.

□ **I DO NOT** grant any access to my parents and / or guardians. **No medical information records or appointment information can be discussed or released.**

This content if valid from date signed. I understand that I can withdraw this consent at any time in writing.

Patient Signature:	**Date:**