

18 & Over - HIPAA Release and Consent 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, and or appointment status without my specific written permission. Kidz World Pediatric Dentistry 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 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 (please print name of parent or guardian):

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

_____ 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 member of the Kidz World Pediatric Dentistry staff to schedule appointments, discuss my healthcare, and access my complete medical records. THEY HAVE NO RESTRICTIONS.

_____ I give the above-named individual(s) permission to contact and speak with any provider or member of Kidz World Pediatric Dentistry staff for the sole purpose of scheduling an appointment. NO access to my medical records or information regarding my care can be discussed or provided. APPOINTMENT ACCESS ONLY.

Patient Printed Name Date

Patient Signature Date

