Adolescent Confidentiality / Release Form

Patient Name	Date of Birth	Telephone #	
Street Address	City	State	Zip

As a legal adult, I understand that all information that I discuss with my physician will be strictly confidential and any communications from Child and Adolescent Health Specialists, PC will be discussed with me directly. I also understand, however, that I may wish to authorize Child and Adolescent Health Specialists, PC to speak with my parent(s) regarding specific issues related to my medical care.

I hereby authorize Child and Adolescent Health Specialists, PC to discuss the following information (check all that apply)

- ❑ Appointment scheduling
- ❑ Medication requests/refills
- ❑ Referrals
- ❑ Insurance/billing
- ❑ Medical care/treatment/lab results with the ***EXCLUSION*** of any reference to: (circle all that apply) drug/alcohol usage, venereal disease, abortion, genetic testing, HIV testing, AIDS diagnosis/treatment, mental health treatment, or other protected information (please specify) ____

with the individual(s) listed below:

Name(s): ____

Relationship to patient: ❑ Parent(s) ❑ Other ______________________________

Address: ____

Telephone #: ____

❑ I do **NOT** authorize Child and Adolescent Health Specialists, PC to discuss any issues related to my medical care with my parent(s).

This authorization will expire on my 21st birthday or once I have left the practice of Child and Adolescent Health Specialists, PC, whichever comes first.

I understand that I may revoke this consent at any time by signing the Revocation Statement below, however such revocation does not affect any actions taken by Child and Adolescent Health Specialists, PC before I signed the Revocation Statement.

Signature: ______________________________________ Date: ______________

REVOCATION STATEMENT:
I revoke the above authorization as of the date listed below.

Signature: ______________________________________ Date: ______________