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### CONSENT FOR 18+ AND EMANCIPATED MINORS

Name of Patient \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

I understand that I am classified as a legal adult under the law. This means that my parents and/or legal guardians may NOT access my health information, under the HIPPA Patient Privacy Acts. In full knowledge of my rights to privacy, I am WAIVING my right to privacy to the following individual(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I consent for the following to be discussed with him/her/them (check all that apply):

- Confidential Laboratory / Radiology Results
- Scheduling and Cancelling of Appointments
- Prescription Information (name and indication of prescription, dosing, refills, etc)
- Health History
- Recent Health Problems
- Other \_\_\_\_\_

### CONSENT FOR TELEPHONE CONTACT

I understand that the office will be contacting me at home or the number of my choosing to confirm appointments.

Home Phone \_\_\_\_\_

Other Phone \_\_\_\_\_ (Cell / Work)

In addition, I consent for the office to (check all that apply):

- Leave a message to report the results of lab test
- Leave other messages

### CONSENT FOR CORRESPONDENCE BY MAIL

I understand that the office will be sending me correspondence by mail.

In addition, I consent for the office to (check all that apply):

- Reminder post cards for annual physical appointments
- Laboratory test results
- All other correspondence from our office by mail

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_