PATIENT AUTHORIZATION (for patients 18 years & older)

Authorization to Discuss & Disclose Information to Parents and Others

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

I Give Permission for Legacy Pediatrics to leave a message/voicemail/text regarding appointments, billing, and/or medical information at the following cell phone number:

CELL NUMBER (PATIENT): _____ **EMAIL**: _____

1. I understand that I can change, cancel, or update this authorization at any time by completing a new form or by notifying the office in writing.
2. I understand that giving consent to disclose personal health information is voluntary and that I have been offered the opportunity to receive a copy of Legacy Pediatrics' Privacy Policies.

☐ **I authorize Legacy Pediatrics to discuss or disclose my personal health information with the following individual(s):**

Parent/Guardian: Name: _____ Relationship to Patient: _____

Parent/Guardian: Name: _____ Relationship to Patient: _____

Other: Name: _____ Relationship to Patient: _____

Confidential Health Information: I authorize the above-named individuals to have access to my protected health information as follows: ***FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS CHECKED OFF AND SIGNED***

	YES	NO	**Patient Signature** *(required)*
Mental Health Information:	☐	☐	_____
Drug and Alcohol Records:	☐	☐	_____
STI / Sexual Activity:	☐	☐	_____

☐ I do not authorize Legacy Pediatrics to discuss or disclose my health information.

PATIENT SIGNATURE: _____ TODAYS DATE: _____