Rocky Hill Pediatrics

1084 Cromwell Ave. Rocky Hill, CT 06067 Office: 860.721.7561 Fax: 860.721.9199

18 Years of Age & Older – HIPAA Release and Consent Form

If you are a patient over the age of 18 years, your parents and/or guardians will no longer be permitted to access your medical records, to discuss your healthcare with medical providers, or to discuss your appointments with our office without your written permission.

Please indicate below whether you would like us to share your medical information with a parent and/or any other caregivers:

_____ **I DO NOT** grant my parents and/or guardians access to my medical information, medical records, or appointment information. I do not give permission to Rocky Hill Pediatrics to disclose and/or release my protected health information.

_____ **I DO** grant my parents and/or guardians access to my medical information, medical records, or appointment information. I give permission to Rocky Hill Pediatrics to disclose and/or release my protected health information to the following persons:

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Please specify if you wish to include the following information (initial Yes or No):

Yes, include	No, do not include	
YES ☐	NO ☐	**Sexually Transmitted Illness (i.e. HIV)**
YES ☐	NO ☐	**Pregnancy / Sexual Activity**
YES ☐	NO ☐	**Mental Health records**
YES ☐	NO ☐	**Alcohol / drug abuse records**

PATIENT PRINTED NAME	**PATIENT SIGNATURE**	**DATE OF BIRTH**
PATIENT CELL PHONE	**EMAIL ADDRESS**	**DATE**