HOLLY SPRINGS PEDIATRICS

106 Hyannis Drive
Holly Springs, NC
27540
(T) 919-249-4700

Over 18 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. Holly Springs Pediatrics 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 physician or member of the Holly Springs Pediatrics 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 physician or member of Holly Springs Pediatrics 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.**

___I give the above-named individual(s) permission *to request refills and pick up my prescriptions*.

_____ _____
Patient Printed Name Date

_____ _____
Patient Signature Holly Springs Pediatrics Witness

This consent is valid for one year from the date signed. I understand that I can withdraw consent at any time by providing Holly Springs Pediatrics with written notice indicating the changes in access.