

ELMWOOD PEDIATRIC GROUP – TEEN PATIENT AUTHORIZATION

Authorization to Discuss and Disclose Information to Parents and others

1. By signing below, I authorize Elmwood Pediatric Group to discuss my medical history, care, appointments, prescriptions, referrals and lab results with the people I have listed.
2. This authorization is valid until I reach the age of _____. I also 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.
3. I understand that signing this form is voluntary and that the Elmwood Pediatric Group has privacy policies in place to protect my rights.
4. I also give permission to Elmwood Pediatric Group to leave a message on the answering machine/voice mail at the following telephone number _____ and email address _____ regarding () medication and/or () appointments.

The people who are authorized to discuss my medical care are:

- () Mother _____
- () Father _____
- () Other _____

The information that may be discussed includes:

- () Complete Medical Records EXCEPT: STD/HIV/sexual activity information, drug, alcohol and treatment information and mental health information.
- () Exclude other information as described below:

OR () I am 18 years old and I do not authorize anyone to discuss my medical information.

PRINTED PATIENT NAME: _____

Patient Signature: _____

Date of Birth: _____

Date Signed: _____ Updated: _____

Witness initial and date: _____