Pavilion Pediatrics at Green Spring Station, P.A.
10755 Falls Road, Suite 260
Lutherville, Maryland 21093
Phone: (410) 583-2955 Fax: (410) 583-2962
www.pavilionpediatics.net

HIPAA Release and Consent Form

I understand and acknowledge that by being 18 years of age or older, my parents and/or guardians no longer have access to my medical records, personal information, providers, or appointment status without my specific written consent, under Federal and State Notice of Privacy Practices regulations. Pavilion Pediatrics at Green Spring Station, P.A. may not speak with my parents and/or guardians to schedule appointments, fill or refill prescriptions, or release personal and/or medical information to my parents without my written consent as indicated in this document.

_____ **I DO NOT** grant access to my parents and/or guardians. **No medical record information, personal information or appointment information may be discussed or released.** I understand that I will schedule all of my appointments with Pavilion Pediatrics at Green Spring Station, P.A. and contact Pavilion Pediatrics at Green Spring Station, P.A. to update my personal information and/or request prescriptions and/or prescription refills.

_____ **I DO WISH TO** grant my below listed parents and/or guardians access to my healthcare providers and/or medical information as follows:

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____ 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 staff at Pavilion Pediatrics at Green Spring Station, P.A. to schedule appointments, request prescriptions and/or prescription refills, discuss my healthcare, and access my complete medical record. **I understand this gives the listed parents and/or guardians full and unrestricted access to my Protected Health Information (PHI), as outlined in the Health Insurance Portability and Accountability Act (HIPAA).**

_____ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Pavilion Pediatrics at Green Spring Station for the **sole purpose of scheduling an appointment on my behalf**. NO access to my medical record, personal information, or information regarding my care may be provided or disclosed.

_____ I give the above named individual(s) permission **to only request refills and pick up my prescriptions on my behalf.** NO access to my medical record, personal information, or my care may not be provided or disclosed.

_____	_____	_____
Patient Printed Name	Patient Birth Date	HIPAA Signature Date
_____	_____	
Patient Signature	Pavilion Pediatrics at Green Spring Station, P.A. Witness	

This consent is valid for one year from the date signed. I understand that I have the right to withdraw my signed consent at any time by providing Pavilion Pediatrics at Green Spring Station with written notice indicating the changes in access.

I understand that this consent has no impact on whether or not I am covered under my parent/guardian's healthcare plan. Charges for my services are still billable to my parent/guardian's healthcare plan without their access to my PHI.