OVER 18 YEARS OF AGE AUTHORIZATION TO RELEASE INFORMATION

I, _____, understand as a patient aged 18 or older that my medical information will no longer automatically be shared with my parents. I acknowledge that I must give authorization to the providers and staff at Pediatrics at Wakefield Pediatrics to discuss my medical care and concerns with anyone other than myself.

- ☐ ***I give*** authorization to the providers at Wakefield Pediatrics to discuss my medical information with the people listed below:
- ☐ ***I do not give*** authorization to the providers at Wakefield Pediatrics to discuss my medical information with anyone other than myself.

***Confidential information includes mental health, substance abuse, sexual health, sexually transmitted infection/AIDS/HIV testing and results.**

- ☐ ***I give*** authorization to the providers at Wakefield Pediatrics to discuss the above confidential information with the people listed below:
- ☐ ***I do not give*** authorization to the providers at Wakefield Pediatrics to discuss the above confidential information with anyone but myself.

I fully understand and accept the terms of this consent. I understand that I may revoke this consent at any time, and that I must notify Wakefield Pediatrics in writing.

Authorized Person	**Relationship**
_____	_____
_____	_____
_____	_____

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PATIENT PRINTED NAME **CELL PHONE NUMBER**