Pediatric Health Care at Newton Wellesley

Health Care for the Next Generation

I understand and acknowledge that as of my 18th birthday, my parents/guardians will no longer be permitted to access my medical records, information, providers and appointment status without my specific written permission. Pediatric Health Care will not speak with my parents with regard to the above mentioned nor will they release my medical records without my written consent in accordance with this document. I understand I may withdraw consent at any time by providing Pediatric Health Care with written notice indicating the changes in access.

_____ **I <u>do not wish to grant</u> access to my health care information. No medical information, Records, or appointment information can be discussed or released.**

I **<u>wish to grant</u>** the below named person(s) access to my health care providers and/or medical information.

_____ _____

Name(s) Relationship to Patient

_____ I give permission to act on my behalf with **no limitations.** I understand that they may contact Any physician or staff member at Pediatric Health Care with **<u>NO RESTRICTION.</u>**

_____ I give permission to act on my behalf **with limitations.** They may contact any physician or Staff member at Pediatric Health Care for **<u>appointment access only.</u>**

_____ I give permission to act on my behalf **with limitations.** They may contact any physician or Staff member at Pediatric Health Care for **<u>prescription refill and pick up.</u>**

_____ _____

Patient Name Date

_____ _____

65 Walnut Street, Suite 310
Wellesley, MA 02481
frontdesk@pediatrichealthcare.com
(781) 772-1527

Patient Signature

Pediatric Health Care Witness

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