PATIENTS 18+ AND EMANCIPATED MINORS

Authorization to Release Protected Health Information (PHI)

Walden Pond Pediatrics
Boston Children's
Primary Care Alliance

waldenpondpediatrics.com
978-369-9401 | *fax* 978-371-8810

Patient name: _____

Date of birth: _____

I understand that I am classified as a legal adult under the law. This means that my parents and/or legal guardians may NOT access my health information, under the HIPAA Patient Privacy Acts. In full knowledge of my rights to privacy, I am WAIVING my right to privacy to the following individual(s):

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

I consent for the following to be discussed with him/her/them (check all that apply)**:**

❑ Confidential laboratory/radiology results

❑ Scheduling and cancelling of appointments

❑ Prescription Information (name and indication of prescription, dosing, refills, etc.)

❑ Health history

❑ Recent health problems

❑ Other: _____

Consent for telephone contact

I understand that the office will be contacting me at home or the number of my choosing to confirm appointments.

Phone: _____ ❑ Preferred

❍ Home ❍ Office ❍ Cell ❍ Other

Phone: _____ ❑ Preferred

❍ Home ❍ Office ❍ Cell ❍ Other

Phone: _____ ❑ Preferred

❍ Home ❍ Office ❍ Cell ❍ Other

In addition, I consent for the office to (check all that apply):

❑ Leave a message to report the results of lab test

❑ Leave other messages

Consent for correspondence by mail

I understand that the office will be sending me correspondence by mail. In addition, I consent for the office to send (check all that apply)**:**

❑ Reminder post cards for annual physical appointments

❑ Laboratory test results

❑ All other correspondence from our office by mail

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign and fill in the information below.

Parent/Guardian name: _____

Relationship to patient: _____

Signature: _____

Date: _____