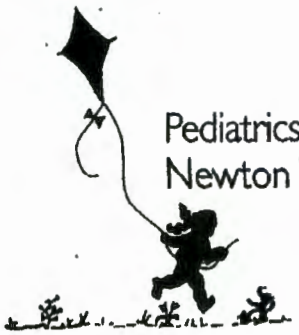

Pediatrics at
Newton Wellesley, P.C.

Eileen Kramer, MD, FAAP ◆
Susan Reuter, MD, FAAP ◆
Tetiana Pronchick, MD, FAAP ◆
Michael Elkort, MD, MA, FAAP ◆
Qian Yuan, MD, PhD, FAAP ◆
Brinda Trivedi Gupta, MD, FAAP

Genevra Casals, RN, MSN, CPNP ◆
Rachel Sarasohn, RN, MSN, CPNP ◆
Nicole Hersel, RN, MSN, CPNP ◆
Kathleen James, RN, MSN, CFNP, CLC ◆
Kayla O'Brien, RN, MSN, CPNP

OVER 18 YEARS OF AGE AUTHORIZATION TO RELEASE INFORMATION

I, (print name) _____, understand as a patient age 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 Newton Wellesley (PNW) to discuss my medical care and concerns with anyone other than myself.

CONFIDENTIAL INFORMATION WILL NOT BE DISCUSSED WITH ANYBODY (regardless of the box checked below). Confidential information includes mental health, substance abuse, sexual health, sexually transmitted infection/AIDS/HIV testing and results.

☐ I ***do not give*** authorization for my medical information to be discussed with anyone other than myself.

☐ I ***give*** authorization to the providers at PNW to discuss my medical information with the people listed below:

Authorized Person	Relationship
	Parent/Guardian
	Parent/Guardian

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 Pediatrics at Newton Wellesley in writing.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PATIENT PRINTED NAME CELL PHONE NUMBER

Boston Children's Hospital

Pediatrics at Newton Wellesley
18+ registration form

Patient Information:

First name _____ MI. _____ Last Name _____

Date of Birth: _____ Sex (circle one) Male Female other

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Cell phone #: _____

Email address: _____

Emergency Contact Information:

Parent 1 name: _____	Parent 2 name: _____
Relationship to child: _____	Relationship to child: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____	State: _____
Primary phone #: _____	Primary phone #: _____
circle one: cell home work	circle one: cell home work

Preferred Pharmacy:
Name: _____ City & Phone: _____

Medical Insurance nformation:

Insurance name: _____
Member ID: _____ Group #_____
Holder of insurance: _____ SSN: _____
Employer: _____

I hereby authorize my insurance benefits to be paid to Pediatrics at Newton Wellesley, PC, and acknowledge that I am responsible for any balance not covered by those benefits. Delinquent accounts will be submitted to a collection agency, and any collection fees will be the parents or guardian's responsibility.

Signature: _____ Date: _____