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AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

TO PARENT and/or PERSONAL REPRESENTATIVE

For Patients ≥18yrs

Patient Name_____ **DOB**_____

Cell number _____

I understand that as of my 18th birthday, my parents/guardian will no longer be permitted to access my medical record without my specific written permission.

We at Dowd Medical believe that parents should be partners in their child's healthcare needs at every age, however we must obtain permission from you to share this privileged information.

Please initial below:

_____I give permission to Dowd Medical to share my medical records, speak with my parents/guardian, make appointments or have my parents/guardian call on my behalf.

These records can be shared with:

Parent/Guardian_____ **Cell number**_____

Parent/Guardian_____ **Cell number** _____

Other _____ **Cell number**_____

_____ **I do not consent to sharing any of my medical information.**

This consent is valid for 1 year from the date signed. I understand that I can change this authorization at any time but must submit a new letter in writing indicating any changes.

Patient Name_____

Patient Signature_____ **Date**_____