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AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

TO PARENT and/or PERSONAL REPRESENTATIVE

For Patients ≥18yrs

Patient Name: _____
DOB: _____
Cell number: _____
Email: _____

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_____