Elmwood Pediatric Group, LLP

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ADULT PATIENT AUTHORIZATION (for patients 18 years & older)

Authorization to Discuss & Disclose Information to Parents and Others

PATIENT NAME ________________________ DATE OF BIRTH ___________ AGE_____

I Give Permission for Elmwood Pediatric Group to leave a message/voicemail/text regarding appointment, billing and/or medical information at the following cell phone number:

CELL NUMBER (PATIENT): _____________________ EMAIL: ______________________________

1. I understand that I can change, cancel or update this authorization at any time by completing a new form or by notifying the office in writing.
2. I understand that signing this form is voluntary and that Elmwood Pediatric Group has Privacy Policies in place to protect my rights.

If you wish to authorize Elmwood Pediatric Group to discuss your medical care with anyone else, please complete the following as appropriate (OPTIONAL):

☐ **Parent/Guardian**: Name: _________________ Relationship to Patient: _______________

☐ **Parent/Guardian**: Name: _________________ Relationship to Patient: _______________

☐ **Other**: Name: _________________ Relationship to Patient: _______________

The Information that may be discussed includes (PLEASE ☑ ONE BOX ONLY):

☐ My Personal Health Information including: **INITIAL IF YOU CONSENT TO THE FOLLOWING*:

*_____ Mental Health Information
*_____ Drug, Alcohol & Treatment Information
*_____ STD/Sexual Activity

☐ My Personal Health Information with the following exclusions (please specify): __________________
____

☐ I do not authorize anyone to discuss my personal health information

PATIENT SIGNATURE: _________________________ TODAYS DATE: _____________