Carolyn T. Cleary, M.D., F.A.A.P.
William J. Hoeger, M.D., F.A.A.P.
Claire Wyman, D.O., F.A.A.P.
Myriam F. Bauer, M.D., F.A.A.P.
Mary B. Porter, M.D., F.A.A.P.
Jessica A. Kleinberg, M.D., F.A.A.P.
Sarah E. Hodges, M.D., F.A.A.P.
Dan-Thanh Nguyen, M.D., F.A.AP.
Emilia Nymander, D.O.
Ann B. Sorrento, M.S., P.N.P.

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 giving consent to disclose personal health information is voluntary and that I have been offered the opportunity to receive a copy of their Privacy Policies.

☐ **I authorize Elmwood Pediatric Group to discuss or disclose my personal health information with the following individual(s):**

☐ **Parent/Guardian**: Name: _____ Relationship to Patient: _____

☐ **Parent/Guardian**: Name: _____ Relationship to Patient: _____

☐ **Other**: Name: _____ Relationship to Patient: _____

Confidential Health Information: I authorize the above-named individuals to have access to my protected health information as follows: ***THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS CHECKED OFF AND SIGNED***

	YES	NO	**Patient Signature** *(required)*
Mental Health Information:	☐	☐	_____
Drug and Alcohol Records:	☐	☐	_____
STD / Sexual Activity:	☐	☐	_____

☐ **I DO NOT authorize Elmwood Pediatric Group to discuss or disclose my health information.**

PATIENT SIGNATURE: _____ TODAYS DATE: _____