HARBOR PEDIATRICS MEDICAL GROUP

18 YEAR OLD HIPAA CONSENT FORM

On this form you will need to tell us if your mom, dad, step-mom, step-dad or any other person can participate in your health care and have access to your health information.You do not have to allow anyone else to participate in your health care. Participating in your health care includes, scheduling appointments on your behalf, requesting referrals, getting lab or x-ray results, talking to your doctor or nurse practitioner, and seeing your records. This is your personal decision to make. We want you to make the best choice for your health care needs.

I, _____, give the following people permission to participate in my healthcare:

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

Patient Signature: _____ **Date:** _____

Patient E-mail: _____ **Patient Cellphone:**_____