Patient Responsibility Agreement
Over 18 HIPAA Release and Consent

SUBURBAN PEDIATRICS
Phone: (716) 565-9030 | Fax: (716) 565-9038
www.suburbanpediatrics.com

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Suburban Pediatrics will not speak with my parents, permit my parents to schedule appointments or provide medical information to my parents unless in accordance with this document.

I wish to grant my parents and/or guardians access to my healthcare providers and/or medical information as follows: (**You must select only ONE option and initial**)

PRINT THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF

____
(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

____
(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

☐ I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Suburban Pediatrics to schedule appointments, discuss my healthcare and access my medical records. **THEY HAVE NO RESTRICTIONS**.

☐ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Suburban Pediatrics to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS**.

☐ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Suburban Pediatrics for the sole purpose of scheduling an appointment. No access to my medical records or information regarding my care can be discussed or provided. **APPOINTMENT ONLY ACCESS**.

☐ **I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIAN. NO MEDICAL INFORMATION, RECORDS OR APPOINTMENT INFORMATION CAN BE RELEASED**.

This consent is valid for one (1) year from the date signed. I understand that I can withdraw consent at any time by providing Suburban Pediatrics with a written consent indicating the changes in access.

________________________________	____________________
PATIENT NAME (Print Legibly)	PATIENT DOB
(________) ________________________	(________) ________________________
PATIENT CONTACT # / CELL PHONE	ALTERNATE PHONE #
________________________________	
PATIENT E-MAIL ADDRESS	
________________________________	____________________
PATIENT SIGNATURE	DATE
________________________________	____________________
SUBURBAN PEDIATRICS WITNESS	DATE