20925 Professional Plaza Suite 100, Ashburn, VA 20147
P: (703)723-8900 F: (703)723-8400

Patient Name **(Print)**: _____ Today's Date: _____

Patient Date of Birth:_____

AUTHORIZATION FOR RELEASE OF INFORMATION BY PATIENT OVER 18 YEARS OLD

DESCRIPTION OF "PROTECTED HEALTH INFORMATION" TO BE USED OR DISCLOSED

I understand that it is the policy of Whole Child Pediatrics. (the "Practice") to protect my privacy and to follow all state and federal privacy laws. However, I also understand that in order to **involve my parents or other individuals in my medical care** it will be necessary for the Practice to use/disclose some of my medical information ("Protected Health Information"). I understand that my Protected Health Information to be disclosed may include information regarding genetic testing, HIV / AIDS status, mental health diagnosis and treatment and substance abuse diagnosis and treatment, pregnancies and/or pregnancy test results and I hereby specifically authorize the Practice to disclose such information to the persons listed below:

I hereby authorize the disclosure of my Protected Health Information to the following individual(s):

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

PATIENT'S RIGHTS

I understand that I have the right to refuse to sign this Authorization to release my Protected Health Information. If I refuse to sign this Authorization, the Practice will in no way deny me my rights concerning treatment, payment for services, and enrollment in a health plan or eligibility for benefits.

I understand that I may revoke this Authorization at any time after I have signed it by providing the Practice with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my Protected Health Information will no longer be used / disclosed pursuant to this Authorization except when **medically necessary in an emergency situation.**

I specifically authorize the disclosure of my Protected Health Information as set forth in this Authorization. I understand that if my Protected Health Information is disclosed, then this information may be subject to re- disclosure by the recipient and may no longer be protected by the federal patient privacy laws. For example, the recipient may request that Protected Health Information be provided to a school or camp.

This Authorization, unless I earlier revoke it, shall remain in effect for **as long as I am an active patient at the Practice.**

_____
Patient's Signature

ONLY sign below if you are <u>REFUSING</u> to release your medical records.
Form Presented to Patient – Patient refused to provide authorization :_____ Date :_____

18 Year Old – Email and Phone Contact

In order to communicate with our patients and families more efficiently, we are asking for an updated email address and phone number. This will only be used for important messages and we will not share your email address or phone number with anyone else.

Please fill out this form with a current email address where you would like us to send messages.

Thank you for helping us to serve you better!

_____

Patient Name (Print) **Date of Birth:**

Patient's Name (Signature):

_____

Email Address:

_____

Phone Number (including area code): Cell ☐ Home Work ☐

_____

Ok to leave medical information on Voicemail: Yes ☐ No ☐

Whole Child Pediatrics

18 YEAR - PERMISSION TO PICK UP PRESCRIPTIONS

Note: This form authorizes permission to pick up prescriptions from any persons other than Patient whose name is signed below

Name: Date of Birth:

_____ (**Patient)**

I give the following individual(s) my permission to pick up any prescription or Medication (including a controlled substance). I understand that such authorization does not cover consent to major surgery or any treatment provided outside the offices of Whole Child Pediatrics.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

Check one of the following boxes:

☐ This notice is effective only on the following date(s): _____ _____

☐ This notice is effective from the date below until revoked.

I understand that this notice will not expire unless revoked by me in writing.

_____

Patient – Print Name

_____ _____

Patient - Signature Date

VERBAL CONSENT OBTAINED FROM - Patient

Name of Patient: _____

Date: _____

Verbal consent effective only on the following date: _____

Name of individual documenting consent: _____

Form sent to Patient to follow-up on verbal consent on (insert date): _____