Over 18 HIPAA Release and Consent to Discuss

ANCHORAGE PEDIATRIC GROUP
3340 Providence Drive, Suite 500-Building A, Anchorage, AK 99508
T. 907-562-2423 / F. 907-563-1170

Printed Patient Name _____ Patient DOB _____

Patient Phone Number _____ Patient Email _____

I understand and acknowledge that as of my 18th birthday, I am considered an adult and I am responsible for my own healthcare. By law, my parent(s) and/or guardian(s) will no longer be permitted access to my medical records or be able to discuss appointments or healthcare information with providers without my specific written permission.

○ I do not authorize anyone other than myself access to my medical records

OR (fill out the box below)

○ I WISH TO grant my parent(s) and/or guardian(s) access to my healthcare providers and/or medical information as follows:

☐ I give the below-named individual(s) permission to contact any physician or member of the staff at APG to discuss my healthcare and medical records.

☐ I give the below named-individual(s) permission to contact and speak with any physician or member of the staff at APG for billing purposes.

☐ I give the below-named individual(s) permission to request refills and pick up my prescriptions.

_____ _____
Printed Name of Parent/Guardian Relationship to you

_____ _____
Printed Name of Parent/Guardian Relationship to you

_____ _____
Printed Name of Parent/Guardian Relationship to you

I understand that I can withdraw this consent at any time by providing Anchorage Pediatric Group with written notice indicating the changes in access.

Patient Signature _____ Date _____

For Office Use ONLY
Staff reviewed: _____ Date scanned to chart: _____

Effective 06/14/2019, Updated 7/7/2022