

Authorization for Access to Personal Health Information Upon Reaching Age 18

Patient's Full Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

I authorize Carolina Kids to allow the following individuals to have access to my protected health information as specified below:

Name: _____ Relationship: _____

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Please check YES or NO for each item below:

Yes No — 1. Allow this individual to schedule and cancel appointments on my behalf.

Yes No — 2. Permit discussion of my medical concerns with a nurse or physician.

Exclusions (e.g., mental or sexual health): _____

Yes No — Allow this individual to pick up prescriptions or medical forms on my behalf.

Yes No — Allow this individual to receive immunization records or school/camp forms.

Yes No — Allow this individual to discuss insurance and payment issues.

Yes No — 3. Send billing statements to the responsible party currently on file.

NOTE: This may alert them that you were seen in our office.

If **NO**, provide your updated billing address below and understand that you are accepting personal responsibility for any balances owed.

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

I understand that if Carolina Kids files my insurance, the insurance company may give access to or send information to the primary policy holder regarding your visit. *See a staff member if you wish to decline insurance filing.*

I understand that this authorization excludes patient portal access and that only I can allow other users access to my portal account.

I understand that if I give authorization to have my protected health information disclosed to a third party who is not required to comply with HIPAA regulations, then the third party may not protect my information.

I understand that I have the right to revoke this authorization at any time and that my revocation must be in writing. Completing an updated copy of this form can be considered a written revocation.

I have read the above terms and I am aware that a copy of the authorization is available upon request at any time. Unless revoked or replaced, this authorization will expire two years from the date it is signed.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____