Confidentiality/Release Form

MVPediatrics
Health and Wellness Center

Patient Name _____	DOB _____	Cell # _____
Street Address _____	City _____	State_____ Zip _____

As a legal adult, I understand that all information that I discuss with my physician will be strictly confidential and any communications from MVPediatrics will be discussed with me directly. I also understand, however, that I may wish to authorize MVPediatrics to speak with my parent(s) regarding specific issues related to my medical care.

⇨ **I do NOT authorize MVPediatrics** to discuss any issues, provide access to, or release any information related to my medical care with my parent(s)/other individuals.

OR ----------

⇨ **I hereby authorize MVPediatrics** to communicate or release the following information (initial all that apply)

___ Appointment scheduling

___ Medication requests/refills

___ Referrals

___ Insurance/billing

___ Medical care/treatment/lab results with the EXCLUSION of any reference to the sensitive information indicated below

⇨ I hereby authorize MVPediatrics to communicate or release the following **sensitive information** (initial all that apply)

___ Drug/alcohol usage

___ Sexual practice

___ Abortion

___ Genetic testing

___ Sexually Transmitted Infection (STI) testing/diagnosis/treatment

___ HIV/AIDS testing/diagnosis/treatment

___ Mental health treatment

___ Other protected information (please specify) _____

with the individual(s) listed below:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

This authorization will expire upon written revocation or once I have left the practice of MVPediatrics.

I understand that I may revoke this consent at any time by signing the Revocation Statement at the bottom of this page, however, such revocation does not affect any actions taken by MVPediatrics before I signed the Revocation Statement.

Signature: _____ Date: _____

REVOCATION STATEMENT: *I revoke the above authorization as of the date listed below.*

Signature: _____ Date: _____