PEDIATRIC AND YOUNG ADULT MEDICINE, P.A.

PATIENTS AGE 18 OR OLDER

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

Patient Name:_____ Birth date_____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Pediatric and Young Adult Medicine, PA Providers and staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient: _____ Phone # _____

Name: _____ Relationship to Patient: _____ Phone # _____

Name: _____ Relationship to Patient:_____ Phone # _____

Conditions for Disclosure (Check the item(s) that apply):

□ Pediatric and Young Adult Medicine, P.A. may disclose my medical information to the individual(s) listed above when I am not physically present, including disclosures by telephone, facsimile, email or regular mail.

PLEASE NOTE:

Pediatric and Young Adult Medicine will not disclose confidential information without a specific release.

See below:

I authorize the release of information relating to:

- □ Alcohol/Drug Abuse Evaluation/Treatment
- □ HIV/AIDS/STD Evaluation/Treatment
- □ Psychiatric/Mental Health Evaluation/Treatment
- □ Pregnancy Evaluation/Treatment

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signed: _____