Our Village Pediatrics, LLC 115 Academy Street, Suite 101 Canton, GA 30114
Dr. Stephanie Hassel McNeil

HIPAA Release and Consent Form for 18yr +

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission.

Our Village Pediatrics will not speak with or permit my parents/guardians to schedule appointments, nor release medical information to my parents/guardians without my written consent in accordance with this document. This includes access to the patient portal.

____I DO NOT grant any access to my parents and/or guardians. No medical information, records or appointment information can be discussed or released for the purpose of helping me with my healthcare.

_____ I WISH TO grant my parents and/or guardian access to my healthcare providers and/or medical information as follows:

I give the below-named individual(s) permission to act on my behalf. I understand that they may contact any physician or member of the staff at Our Village Pediatrics to schedule appointments, discuss my healthcare, and access my medical records.

Please specify if you wish to include the following (Initial Yes or No):
_____Sexually Transmitted Disease/ Communicable Diseases
_____Pregnancy/Sexual Activity
_____ Mental Health
_____Substance Abuse

Printed name of parents/guardians whom you grant access:

1._____ 2. _____

I understand that: The purpose is provided above so that I can make a decision as to whether to allow the release of information. I do not have to sign this authorization in order to receive treatment. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule or other law protecting its confidentiality. I have the right to revoke this authorization in writing, except where the office has acted in reliance upon it.

I also understand that if I am covered under my parent's health insurance, they will be responsible for the billing and have access to billing codes associated with an office visit.

IF YOU DO NOT WISH TO SUBMIT A CLAIM TO YOUR HEALTH INSURANCE FOR AN OFFICE VISIT, YOU WILL BE RESPONSIBLE FOR THE PAYMENT UP FRONT PRIOR TO TREATMENT.

Printed Name:_____DOB:_____

Signature:_____Date:_____