South Lake Pediatrics
Infant, Child & Adolescent Care

Consent To Communicate
For patients 18 years of age and older

_____ DOB _____/_____/_____

Patient Last Name First Name MI

_____-_____-_____

Patient Phone Number

This form is for adult patients 18 years or older. South Lake Pediatrics encourages all patients, regardless of age to have a trusted adult (usually a parent or legal guardian) to participate in your clinic visits. The reason for this is that you may not know your past medical history and our clinicians can provide better service if they have complete information. It is South Lake Pediatrics policy to have the parent accompany the patient to the exam room whenever they are present. It is also South Lake Pediatrics policy to have the patient and clinician share, as appropriate, in the decision about who will be present during your visit.

Patients at the age of 18 years must grant permission for others to partake in their health care by identifying who can provide and receive information about their health.

The following list of items includes those which commonly are helpful to be shared with a parent/legal guardian:

- Verbal exchange of information (regarding patient health information, office visits, lab or x-ray results, immunizations, scheduling and future appointments)
- Request and pick up prescription refills
- Access to the Patient Portal (where you can access your medical records online from our electronic medical records system, including immunizations)
- Other (not indicated above) _____

I understand that I am signing this form voluntarily and that I may change my decision at any time. This release will automatically expire in 12 months. I am aware that I must notify South Lake Pediatrics in writing if I would like to revoke this release anytime prior to its expiration. I also understand that if I choose to revoke this release prior to its expiration, it will not affect any information previously authorized and released by South Lake Pediatrics. A copy of this form is as valid as the original. **Regardless if you sign giving consent to communicate, you are still protected by State and Federal law for the following; Substance Abuse, Mental Health, Developmental Disabilities, HIV, STD and Pregnancy information and testing. A separate written statement from the patient must be obtained before this information can be released.**

☐ I hereby authorize (list name(s) of authorized person(s)_____, to share in my healthcare as outlined above.

_____ _____

Patient's signature Date

☐ **Check this box <u>ONLY</u> if you <u>do not want any</u> information released.**

_____ _____

Patient's signature Date