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 Patient Email Address

This form is for patients 18 years or older. South Lake Pediatrics encourages all patients, regardless of age, to have a trusted adult (usually a parent or former legal guardian) to participate in your clinic visits to assist with providing a full picture of your past medical history. It is South Lake Pediatrics policy to have the parent accompany the patient to the exam room whenever they are present unless the patient objects. 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 receive information about their health.

Authorization for Release and Receipt of Medical and Other Information

I authorize South Lake Pediatrics to use or disclose my medical information to the parent, former legal guardian, or other adult noted below in the following ways:

- Verbal and written exchange of health information, with the exclusion of any unchecked categories of information noted below (regarding patient's past and current health information, office visits, lab or x-ray results, immunizations, scheduling and future appointments)
- Request and pick up prescription refills

Additionally, I authorize access or disclosure to the individual noted below in the following manner:

- ☐ Access to the Patient Portal (where you can access your medical records online from our electronic medical records system, including immunizations)
- ☐ Verbal and Written Disclosures related to Mental Health (including diagnoses, appointments, and medications)
- ☐ Verbal and Written Disclosures related to Substance Use (including diagnoses, appointments, and medications)
- ☐ Verbal and Written Disclosures related to STDs, Pregnancy Information and Testing.
- ☐ Other:_____

I understand that South Lake Pediatrics will not condition treatment on whether I sign this authorization. I understand that I am signing this form voluntarily and that I may revoke this authorization at any time by notifying South Lake Pediatrics in writing at healthinformation@slpeds.com. This release will automatically expire in **24** months. 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.

☐ 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 ONLY if you do not want any information released.**

_____ _____

Patient's Signature Date