Grayson Pediatrics, LLC
297 Cooper Road
Loganville, GA 30052
Office: 678-381-2630
Fax: 678-381-2627
Email: Admin@GraysonPediatrics.com

Over 18 HIPPA Release and Consent Form

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. Grayson Pediatrics, LLC will therefore not speak with my parents or release medical information to my parents without my written consent in accordance with this document.

☐ **I DO NOT** grant access to my parents and or/guardians. **No medical information, records or appointment information can be discussed or released.**

☐ **I WISH TO** grant only my parents and/or guardian who are specifically listed below access to my healthcare providers and or/medical information:

(Print Name of the parents or guardian; including his/her relationship to you.)

Please choose one of the following options:

☐ I give the above-named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Grayson Pediatrics, LLC to discuss my healthcare and access my complete medical records. **THEY HAVE NO RESTRICTIONS.**

☐ I give the above-named individual(s) permission to *request refills and pick up my prescriptions.*

☐ I give the above-named individual(s) permission to contact and speak with any physician or member of the staff at Grayson Pediatrics, LLC for ***the sole purpose of:***

_____ _____

PATIENT PRINTED NAME PATIENT SIGNATURE

_____ _____

DATE GRAYSON PEDIATRICIS, LLC WITNESS