PATIENTS 18 AND OVER

Authorization to Speak with Parent or Guardian

Commonwealth Pediatrics
Boston Children's
Primary Care Alliance

commonwealthpediatrics.com
781-451-0072 | *fax* 781-435-0792

Patient name: _____

Date of birth: _____

Parent/Guardian name(s):

_____

_____

_____

_____

I understand that as a patient 18 years of age or older I must give authorization to the providers and staff of Commonwealth Pediatrics to verbally discuss my medical care and concerns with anyone other than myself. I understand that I need to sign a new release annually and may update it in writing at any time.

Do you authorize Commonwealth Pediatrics to discuss your medical information with your parent/guardian?

❍ **YES,** my parent(s)/guardian(s) listed above may access the following information (initial if apply):

	Initial
Scheduling/appointment information	_____
Billing and payment information	_____
Routine lab/test results	_____
Refill requests for medications	_____
Developmental disability diagnosis & treatment	_____
Substance use diagnosis & treatment	_____
Medical information, including my symptoms, diagnoses, medications, & treatment	_____
Behavioral health information, including my symptoms, diagnoses, medications, & treatments	_____
Sensitive lab/test results, including HIV, STI, & pregnancy test results	_____

I request the following restrictions:

_____

_____

_____

_____

❍ **NO,** please discuss all aspects of my health care, **including financial responsibility,** with me. I know that, if I am on my parent or guardian's insurance plan, and visits are billed to my insurance, an Explanation of Benefits (EOB) will be sent to my parent or guardian which may give details about my health care. I know I must speak to the office manager prior to my visit if I want strictly confidential care at any time.

Patient signature: _____

Date: _____