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Over 16 HIPAA Release and Consent Form

I understand and acknowledge that as of my 16th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointments status without my specific written permission. Dr. Jared Zeff and the Salmon Creek Clinic will not speak with my parents, permit my parents to schedule appointments, or release medical information to my parents without my written consent in accordance with this document.

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

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

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

(Print Name of second parent or guardian; indicate his/her relationship to you.)

 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 the Salmon Creek Clinic to schedule appointments, discuss my healthcare, and access my complete medical records.

THEY HAVE NO RESTRICTIONS.

 I give the above-named individual(s) permission to contact and speak with any physician or member of the staff at the Salmon Creek Clinic for *the sole purpose of scheduling an appointment*. NO access to my medical record or information regarding my care can be discussed or provided.

APPOINTMENT ACCESS ONLY.

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

PATIENT PRINTED NAME

PATIENT SIGNATURE

DATE

SALMON CREEK CLINIC WITNESS

This consent is valid for three years from the date signed. I understand that I can withdraw consent at any time by providing Salmon Creek Clinic with written notice indicating the changes in access.