A Bright Future Pediatrics

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AUTHORIZATION FOR ACCESS TO 18-YEAR-OLD RECORDS

Patient Name ____ Date of Birth __________________

I, _________________________________, give permission for my medical information to be released to the below named.

I hereby appoint the following adults access to my medical record on my behalf in authorizing medical and surgical care and hospitalization records.

_____________________________________	______________________	__________________
Name of appointed Adult	Relationship to Patient	Phone Number
_____________________________________	______________________	__________________
Name of appointed Adult	Relationship to Patient	Phone Number

This consent applies to but not limited to:
I understand that my medical record may contain information of a sensitive or extremely private nature, including, but not limited to, a history of substance abuse, psychiatric or psychological disorders, abnormal test results, various prescriptions, results of HIV testing, history of sexually transmitted diseases, history of diseases transmitted by intravenous drug use or other high risk behavior, hospitalizations, surgeries, and any other medical or psychological disorder for which I may have been treated.

FINANCIAL RESPONSIBILITY

I understand that payment is expected at the time of services and will ensure that the insurance information and the means to pay the co-pay/co-insurance will be paid at the time of service. I accept full responsibility for the charges accrued in the healthcare of myself if the physician, dentist, hospital, or other ancillary healthcare provider is unable to collect from my insurance company.

______________________________	______________________________	_____________
Signature of Patient	Printed Name of Patient	Date