PSOP KIDS
PEDIATRIC SPECIALISTS OF PLANO

OVER 18 HIPAA RELEASE and CONSENT
Patient Responsibility Agreement

Patient Name:_____ DOB:_____

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 written specific permission. **Pediatric Specialists of Plano** will not speak with my parents, permit my parents to schedule appointments or provide medical information to my parents unless in accordance with this document.

I wish to grant my parents and/or guardians access to my healthcare providers and/or medical information as follows: (you must select only ONE option and initial)

PLEASE PRINT THE NAME(S) OF THOSE WHO MAY ACT ON YOUR BEHALF

Name:_____Relationship_____DOB_____

Name:_____Relationship_____DOB_____

Name:_____Relationship_____DOB_____

____ I give the above named individuals(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at **Pediatric Specialists of Plano** to schedule appointments, discuss my healthcare and access my medical records. **THEY HAVE NO RESTRICTIONS. I DO GRANT ACCESS TO MY MEDICAL RECORDS.**

____ I DO NOT give the above named individual(s) permission to contact or speak with any physician or member of the staff at **Pediatric Specialists of Plano** to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS.**

My signature here means I have read this information and understand it. This consent is valid until revoked in writing. I understand that I can revoke my consent at any time.

Patient Name_____**Signature**_____ **Date**_____

PSOP Witness_____**Signature**_____ **Date**_____