All About Kids Pediatrics
Patients 18 years old and older:
AUTHORIZATION TO RELEASE INFORMATION

I, (print name) ________________________________, understand as a patient age 18 or older that my medical information will no longer automatically be shared with my parents/legal guardians. I acknowledge that I must give authorization to the providers and staff at All About Kids Pediatrics, S.C. to discuss my medical care and concerns with anyone other than myself.

☐ I do not give authorization for my medical information to be discussed with anyone other than myself. I understand this means I will be responsible for my own medical information. This includes scheduling appointments, making changes to my appointments, and requesting records for school and/or work. I will be the only contact for anything related to my information at All About Kids Pediatrics, and **my parent and/or guardian will not be able to speak to the office for any reason on my behalf.**

☐ I give authorization to the providers at All About Kids Pediatrics to discuss my medical information with the people listed below (will also include use of the Patient Portal):

Authorized Person	Relationship

I fully understand and accept the terms of this consent. I understand that I may revoke this consent at any time, and to do so I must notify All About Kids Pediatrics **in writing**.

*****Please PRINT in block or capital letters:**

______________________________ ______________
PATIENT SIGNATURE DATE

______________________________ ______________
PATIENT PRINTED NAME PATIENT DATE OF BIRTH

______________________________ ______________
PATIENT'S CELL PHONE NUMBER PATIENT'S EMAIL ADDRESS