P C PEDIATRIC CARE
R OF ROCKVILLE, P.A.

OVER 18 HIPAA RELEASE AND CONSENT FORM

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, or appointment status without specific written permission. Pediatric Care of Rockville, P.A. (PCOR) 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 understand that the clinic has chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, my health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. I may "opt-out" and disable access to my health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org . Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

I wish to grant my parents and/or guardians access to my healthcare providers and/or medical information as follows:

PRINT THE NAMES BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF.

_____

(Print name of parent or guardian and indicate relationship.)

_____

(Print name of parent or guardian and indicate relationship.)

____ 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 PCOR to schedule appointments, discuss my healthcare, and access my complete medical records. FULL ACCESS, NO RESTRICTIONS.

____ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at PCOR for the sole purpose of scheduling appointments and refilling/picking up prescriptions. APPOINTMENT AND PRESCRIPTION ACCESS ONLY.

____ I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIANS. No medical information, records, or appointment information can be discussed or released.

Pediatric Care of Rockville
6000 Executive Blvd. Suite 310
Rockville, MD 20852
(P) 301.881.7995
(F) 301.881.8451
pediatriccareofrockville.com

PC PEDIATRIC CARE OF ROCKVILLE, P.A.

This consent is valid for one (1) year from the date signed. I understand that I can withdraw consent at any time by providing Pediatric Care of Rockville, P.A. with a written consent indicating the change in access.

Patient Name: _____

Signature: _____

Date: _____

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