Willow Bend Pediatrics

Michael J. Frank, M.D., F.A.A.P.
Susan J. Sickler, M.D., F.A.A.P.
Shobha Michaels, M.D., F.A.A.P.
Janet Le, M.D., F.A.A.P

Patient Responsibility Agreement • Over 18 HIPAA Release and Consent

Patient Name: _____ Date of Birth: _____

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 specific written permission. Willow Bend Pediatrics 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:

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

_____
Name of Parent or Guardian, Relationship, and Date of Birth

_____
Name of Parent or Guardian, Relationship, and Date of Birth

You must select only ONE option and initial:

_____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 **Willow Bend Pediatrics** 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 **Willow Bend Pediatrics** to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS.**

This consent is valid for one year. I understand that I can withdraw consent at any time by providing **Willow Bend Pediatrics** with a written consent indicating the changes in access.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Today's Date:** _____

WBP Witness: _____ **Today's Date:** _____