



Consent To Communicate For patients 18 years of age and older

Patient Name: _____ Patient DOB: _____

Patient Phone Number: _____

This form is for patients 18 years or older. South Lake Pediatrics encourages all patients, regardless of age, to have a trusted adult (usually a parent or former legal guardian) to participate in your clinic visits to assist with providing a full picture of your past medical history. It is South Lake Pediatrics policy to have the parent accompany the patient to the exam room whenever they are present unless the patient objects. It is also South Lake Pediatrics policy to have the patient and clinician share, as appropriate, in the decision about who will be present during your visit. Patients at the age of 18 years must grant permission for others to partake in their health care by identifying who can receive information about their health.

Patient Portal Access:

At the age of 18, you now have full control over access to your online Patient Portal Account. If you wish to continue having access to your health information online, please indicate the email address you wish to use to receive notifications on:

_____ (Patient Email Address).

Authorization for Release and Receipt of Medical and Other Information:

I authorize South Lake Pediatrics to use or disclose my medical information to the parent, former legal guardian, or other adult noted below in the following ways: **(Please select one of the three options)**

OPTION 1: FULL ACCESS – (Includes Patient Portal Access)

- Access to the Patient Portal (where you can view your past and current health information, office visits, lab or x-ray results, immunizations, and view future appointments, including all the options below) from our electronic medical records system.

OPTION 2: LIMITED ACCESS – CHECK ALL THAT APPLY: (Does NOT Include Patient Portal Access)

- Verbal and Written Disclosures related to Mental Health (including diagnoses, appointments, and medications)
- Verbal and Written Disclosures related to Substance Use (including diagnoses, appointments, and medications)
- Verbal and Written Disclosures related to STIs, Pregnancy Information and Testing.
- Verbal Communication relating to routine appointments.
- Request and pick up prescription refills.
- Other: _____



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OPTION 3: **NO ACCESS**

- Check this box only if you do not wish to share any of your information or authorize another individual to schedule appointments or request medication refills on your behalf.

I understand that South Lake Pediatrics will not condition treatment on whether I sign this authorization. I understand that I am signing this form voluntarily and that I may revoke this authorization at any time by notifying South Lake Pediatrics in writing at healthinformation@slpeds.com. This release will automatically expire in **24** months. I also understand that if I choose to revoke this release prior to its expiration, it will not affect any information previously authorized and released by South Lake Pediatrics. A copy of this form is as valid as the original.

I hereby authorize _____
(list name(s) of authorized person(s)) to share in my healthcare as outlined above.

Patient's Signature

Date