



Dover Pediatrics

PEDIATRIC & ADOLESCENT MEDICINE

Young Adult Release & Consent Form

I, _____, born on _____, have received a copy of the Young Adult Consent and Confidentiality Statement. I understand that because I am eighteen (18) years of age I have the right to request privacy and autonomy in regard to my medical health information and management.

I also have the ability to grant Dover Pediatrics, PLLC permission to discuss the following information about my health with the following individuals:

I give permission to the following names to receive some or all of my medical health information.

1. _____, relationship: _____
2. _____, relationship: _____
3. _____, relationship: _____
4. _____, relationship: _____

Type of Health care information

All information including my: All of my medical records including all records listed below.

Include just the following record(s) only by checking each record you are willing to share:

- Mental health
 Sexual health/history
 Birth Control
 Sexual orientation
 Pregnancy
 Sexually transmitted diseases
 Drug/Alcohol Abuse
 HIV/AIDS

I understand that I have the right to withdraw my Release & Consent authorization at any time except to the extent that action has been taken relative to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at Dover Pediatrics, PLLC.

This Release & Consent authorization is effective immediately and shall expire one (1) year from the signature date.

Patient's Signature

Date

If you wish to make any changes to this consent form, please contact Dover Pediatrics, PLLC and request a new form.