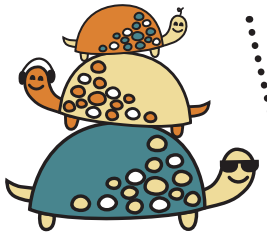

Burkhart
Pediatric &
Adolescent
Dermatology

(919) 476-1118 | (855) 878-6037
135 Parkway Office Court - Suite 201
Cary, NC 27518
info@burkhartpediatricdermatology.com
www.burkhartpediatricdermatology.com

HIPAA Release and Authorization Form for Patients Over 18

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 inquire about appointment status without my specific written permission. Burkhart Pediatric & Adolescent Dermatology, PLLC will not release medical information to my parents without my written authorization in accordance with this document.

_____ **I DO NOT** grant any access to my parents and/or guardians. **No medical information, records or appointment status information can be discussed or released.**

_____ **I WISH TO** grant my parents and/or guardian access to my healthcare providers and/or medical information as follows:
Print Name of the Parent or Guardian; indicate their relationship to you:

_____

Print Name of second parent or guardian; indicate their relationship to you:

_____

_____ I give the above-named individual(s) permission to *act on my behalf with no limitations*. I understand that they may contact any provider or staff member to discuss my healthcare and access my complete medical records. **THEY HAVE NO RESTRICTIONS.**

_____ I give the above-named individual(s) permission to *request refills and pick up my prescriptions.*

_____ I give the above-named individual(s) permission to *access my chart in the patient portal.*

This authorization is valid for one year from the date signed. I understand that I can withdraw consent at any time by providing Burkhart Pediatric & Adolescent Dermatology, PLLC with written notice indicating the changes in access. I understand that authorizing this disclosure of this health information is voluntary. I need not sign this form to assure healthcare or treatment. I understand that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.

Patient Printed Name: _____ DOB:_____

Patient Signature:_____ Date: _____

Patient Contact Number: (_____) _____

I acknowledge that I have received the HIPAA Notice of Privacy Practices _____. (Initials)