

Young Adult Confidentiality/Release Form
For Patients Age 18 Years and Older



Patient Name	Date of Birth	Email
Home Address	Home #	Cell #

As a legal adult, I understand that all information that I discuss with my physician will be strictly confidential and any communications from Performance Pediatrics will be discussed with me directly. I also understand, however, that I may wish to authorize Performance Pediatrics to speak with my parent(s) or other guardian(s) regarding specific issues related to my medical care.

I hereby authorize Performance Pediatrics to discuss the following information (check all that applies):

- Appointment scheduling
- Medication requests/refills
- Referrals
- Insurance/billing
- Medical care/treatment/lab results with the EXCLUSION of any reference to: (circle all that apply) drug/alcohol usage, sexual health, abortion, genetic testing, HIV testing, AIDS diagnosis/treatment, mental health treatment or _____ (write in other specific information).

With the individual(s) listed below:

Name(s): _____
Relationship to patient: Parent(s) Other: _____
Address: _____
Telephone #: _____

OR

- I do NOT authorize Performance Pediatrics to discuss any issues related to my medical care with my parent(s). Further, I understand that I must review and sign the Performance Pediatrics Financial Policy.

This authorization will expire once I have left Performance Pediatrics.

I understand that I may revoke this consent at any time by signing the Revocation Statement below, however such revocation does not affect any actions taken by Performance Pediatrics before I signed the Revocation Statement.

Patient Signature: _____ Date: _____

REVOCAION STATEMENT:

I revoke the above authorization as of the date listed below.

Patient Signature: _____ Date: _____