Date : _____

PATIENT RESPONSIBILITY AGREEMENT
OVER 18 HIPAA/PHI RELEASE AND CONSENT

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. Small Dental 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, medical and/or dental information.

PRINT THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF (please indicate relationship):

Name: _____Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

• I understand that if the person or the entity that receives this information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

• I understand that there may be medical records from another doctor or another medical facility in my chart.

• I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for treatment.

• I understand I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

Patient Name: _____

Patient Signature: _____

Date: _____

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