DOWD MEDICAL ASSOCIATES

107 Woburn St, Stephaie Batson MD Jennifer M. Corwin MD

Reading, MA 01867 Mark J Curdo MD Joan W Sachs Phone: 781 944-4250 Fax: 781 944-2276 Robin A Smith M.D. Michael Sirois PA

 Lucy P. Delaney CPNP

**AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION**

**TO PARENT and/or PERSONAL REPRESENTATIVE**

**For Patients >18yrs**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that as of my 18th birthday, my parents/guardian will no longer be permitted to access my medical record without my specific written permission.

We at Dowd Medical believe that parents should be partners in their child’s healthcare needs at every age, however we must obtain permission from you to share this privileged information.

Please initial below:

­­­­\_\_\_\_\_\_\_\_\_\_\_\_I give permission to Dowd Medical to share my medical records, speak with my parents/guardian, make appointments, or have my parents/guardian call on my behalf.

These records can be shared with:

**Parent/Guardian­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_** I do not consent to sharing any of my medical information.

This consent is valid for 1 year from the date signed. I understand that I can change this authorization at any time but must submit a new letter in writing indicating any changes.

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**