Dear Patient:

As you approach your 18th birthday and become a legal adult, please understand that your parents or legal guardian are no longer considered your legal representative. Under state law and federal HIPAA regulations, you can consent to your own medical care and control your own medical records and information. This means that we can no longer share your records or any medical information about you with your parents, or anyone else, without your written permission.

We do encourage you to continue to discuss, whenever possible, any health problems or concerns with your parents and to continue to seek their advice. If you would like us to be able to share your information with your parents, legal guardian or anyone else, we ask you to fill out and sign the enclosed consent form. Note that you can specify with whom we can share your information. You can allow us to share all of your health information or only part of it. Please specify any information that you do want us to share. Make sure to fill in an expiration date or event. You are welcome, of course, to bring your parent with you when you visit us in the office.

Please complete and sign the attached consent form and return it to us in the enclosed stamped envelope prior to your 18th birthday.

Sincerely,

Advocare _____(Name of care center)

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION TO PARENTS OR LEGAL GUARDIANS

By signing this authorization, I authorize Advocare _____(name of Care Center) to use and/or share certain protected health information (PHI) about me with:

Name Relationship

_____

_____

_____

This authorization permits Advocare _____ (name of Care Center) to use and/or share with the individuals noted above any part of my individual identifiable health information, with the exception of information related to:

Alcohol & drug use **Sexual activity or sexually transmitted disease** **Pregnancy** **Other**

This information will be used to help me make appropriate medical care decisions with the assistance of my parent(s) or legal guardian(s).

This authorization will expire on _____

Expiration date (22nd birthday or other date)

I do not have to sign this authorization in order to receive treatment from Advocare _____(Care Center Name). Additionally, I have the right to refuse to sign this authorization. When my information is used or shared based on this authorization, the recipient may share it with others and my PHI may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the Care Center has acted upon this authorization. My written revocation must be submitted to the Privacy Officer at:

_____
Address

_____
City State Zip Code

Signed by_____
Signature of Patient

_____ _____
Patient Printed Name Date