HOLYOKE PEDIATRIC ASSOCIATES

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Teen Release/Consent for Parents to Obtain Information/Make Appointments

Demographics

Patient Last Name _____ First Name _____ MI_____

Patient Date of Birth _____

Authorization

I give my parents/guardians _____ permission to make appointments and obtain health information, unless otherwise noted, when I am unable to do so. I understand that without an expiration date noted, the authorization will expire 1 year after signature/date on this form.

RELEASE OF SENSITIVE/CONFIDENTIAL INFORMATION

I understand that my medical record may contain information about drug and/or alcohol abuse, psychiatric illness, sexually transmitted diseases, social service involvement, hepatitis B testing/treatment and/or sensitive/confidential information. I agree to the release of this information. ☐ YES ☐ NO

PATIENT SIGNATURE: _____ DATE: _____

RELEASE OF HIV INFORMATION

I understand that my medical record may contain information about HIV (AIDS) testing/treatment. I agree to the release of this information. ☐ YES ☐ NO

PATIENT SIGNATURE: _____ DATE: _____

RELEASE OF MENTAL HEALTH INFORMATION

I understand that my medical record may contain information about my mental health. I agree to the release of this information. ☐ YES ☐ NO

PATIENT SIGNATURE: _____ DATE: _____

PATIENT SIGNATURE: _____

TODAY'S DATE: _____

EXPIRATION DATE: _____

PATIENT PHONE # _____

PARENT/GUARDIAN NAME & PHONE # _____

PARENT/GUARDIAN NAME & PHONE # _____