## Manju Elizabeth George, MD, PLLC

## HIPAA Release and Consent Agreement for Patients 18 Years and Older

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will not be permitted to have access to my medical records or information about my care without my specific written permission.

I wish to grant my parent(s)/guardian(s) access to my healthcare providers, appointments and or medication information as follows:

Please print the name(s) and relationship of those who may act on my behalf:

Name: _____ Relationship:_____

Phone:_____

Name: _____ Relationship:_____

Phone:_____

Please select and initial one of the following options:

_____I give the above names individual(s) permission to act on my behalf with no limitations. I understand that they may contact the physician or staff members at Manju Elizabeth George, MD to schedule appointments, discuss my healthcare and access my medical records. THEY HAVE NO RESTRICTIONS.

_____ I **DO NOT GRANT ANY ACCESS** to my parent(s)/guardian(s) for medical records or information that may be accessed or discussed. No appointment information may be released.

Patient's name:_____ DOB:_____

Patient's cell:_____

Patient's signature:_____ Date:_____