SANDERS COURT Pediatrics

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Sanders Court Pediatrics, Ltd. 18 Year Consent

Patients 18 Years and Older
Consent for Discussion with Family Members Excluding Confidential Information

Patient Name (please print)**:** _____ **Date of Birth:** _____

I **agree** to let certain individuals participate in discussions and decisions related to my medical care. I give permission for the physicians of Sanders Court Pediatrics, Ltd. and their staff members to discuss my personal medical information with the following individuals:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

Patient Signature: _____ **Date of Signature:** _____
Witness: _____ **Date of Signature:** _____

I **do not agree** to let any other individuals participate in discussion and decisions related to my medical care. The physicians of Sanders Court Pediatrics, Ltd. and their staff members should not discuss my personal medical information with any individuals other than myself.

Patient Signature: _____ **Date of Signature:** _____
Witness: _____ **Date of Signature:** _____

Consent for Discussion of Confidential Information

Sanders Court Pediatrics, Ltd. **will not** discuss the following confidential information unless you initial the specific item(s) below.

I authorize the following **confidential** information to be discussed:

_____ Alcohol/Drug Abuse Evaluation and/or Treatment
_____ HIV/AIDS/STD Evaluation and/or Treatment
_____ Psychiatric/Mental Health Evaluation and/or Treatment
_____ Pregnancy Evaluation and/or Treatment

The above confidential information can be discussed with the following individuals:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

- I authorize Sanders Court Pediatrics, Ltd. to discuss the information initialed above.
- I understand that when the health information is discussed, the information may be shared with others by the recipient and may be no longer be protected by federal and/or state privacy laws.
- I understand that my healthcare and payment for healthcare will not be affected if I do not sign this form.

Patient Signature: _____ Date of Signature: _____

Revision Date: 10/11/2017