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MEDICAL AUTHORIZATION FORM (ADULT 18+)

This form is to be used to authorize certain and specific access to the medical records of patients who are over the age of **18 years.**
I understand that my right to confidentiality will be protected, regardless of insurance coverage or relations, and that no information will be released to or discussed with other parties without my express permission and that of my physician. I understand that I can withdraw this authorization at any time.

I, _____, authorize access only for those items indicated and initialed below. (CHECK BOX AND INITIAL EACH SELECTION)

☐ _____Seek medical care and/or appointments on my behalf
Initial

☐ _____Request records to be transferred to another doctor or specialist on my behalf.
Initial

☐ _____Authorize my physician to discuss all medical information with my parent/legal guardian as
Initial named below.

☐ _____Authorize my physician to share/discuss all medical information with another doctor or
Initial specialist. ☐ All Doctors/Specialists ☐ Other (Please Specify)

_____
Doctor/Specialist/Lab/Practice Name
_____

_____ _____
Authorized Adult's Name (PLEASE PRINT CLEARLY) Relationship to Patient

_____ _____
Authorized Adult's Name (PLEASE PRINT CLEARLY) Relationship to Patient

_____ _____
Authorized Adult's Name (PLEASE PRINT CLEARLY) Relationship to Patient

_____ _____
Authorized Adult's Name (PLEASE PRINT CLEARLY) Relationship to Patient

PLEASE CHECK ONE:

☐ Authorization is for all future visits or until I request this authorization be revoked

☐ Authorization in effect for the following dates only_____

Name (PRINT) _____

Signature _____

Date _____

Updated: Aug-12