Treehouse Pediatrics

AUSTIN HEALTH PARTNERS

CONSENT TO USE & DISCLOSE HEALTH INFORMATION

Patient 18 Years and Older

I understand that as part of my healthcare, Treehouse Pediatrics originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments and any plans for future care or treatment.

I understand that as of my 18th birthday, I am considered an adult. Therefore, I need to give written consent to discuss my medical information with anyone other than myself, including my parents.

By signing this form I am designating the parties below with whom I wish Treehouse Pediatrics to be able to discuss my medical information with. I understand that it is my responsibility to inform Treehouse Pediatrics in writing of any changes pertaining to this release.

I, _____, hereby authorize Treehouse Pediatrics to discuss with and release medical information to the individuals below. This release is written without restriction and includes information to mental health.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I understand that as a part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses.

I **fully understand and accept the terms of this consent.**

_____ _____

Signature Date

Patient contact # _____ (best number to reach you, i.e. cell phone)