Metropolitan Pediatrics

18 YEAR OLD WAIVER OR CONSENT

At 18 years old, Metropolitan Pediatrics cannot share your health information without your consent. This document grants or denies permission to share your health information.

Patient Name: _____ Date of Birth: _____

Grant Permission: ☐ Deny Permission: ☐

Mother's Name: _____ Father's Name: _____

Guardian's Name: _____ Other: _____

Please check all boxes you grant permission for Metropolitan Pediatrics to discuss with whom you indicated above. If you do not check any boxes, we will not share any information.

Topic	Mother	Father	Guardian	Other
General or current health status.				
Sexually transmitted diseases.				
Birth control, contraceptives, and or medication management.				
Substance abuse testing and results (e.g., alcohol, drugs). (See individual Consent for Drug Screening form.)				
Mental health issues/medication management. (Includes ADD/ADHD medications, anxiety/depression medications.)				
Release of Information per individual Authorization for Release of Medical Information (includes forms for sporting events, school, asthma action plan, allergy action plan, immunization record or medication administration form requests to be sent to any facility).				

I understand this written notification is effective immediately and indefinitely and can only be revoked or changed by myself. This is in accordance with HIPPA regulations.

Patient Signature: Date: Cell Phone Number:

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If not signed in the office at time of visit the signature requires a Minnesota notary signature.

Add Notary Signature here: