Papago Buttes PEDIATRICS
Phone: (480) 778-1732 Fax: (480) 778-1709
E-Mail: records@papagopeds.com

Consent to Release Medical and Billing Information

(Patients ages 18 and older)

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted to access my medical records, patient information, appointment status or billing account, without my specific written permission. My permission is as follows (check all that apply):

_____ I **DO NOT** grant my parent(s) any access.

_____ I **HEREBY GRANT** my parent(s) permission to access my medical records.

_____ I **HEREBY GRANT** my parent(s) permission to discuss my medical conditions and chart information with the physicians and triage department.

_____ I **HEREBY GRANT** my parent(s) permission to access my billing records for information and/or payments.

Parent(s) information:

Name / Relationship: _____ Phone#: _____

Name / Relationship: _____ Phone#: _____

I understand this authorization will remain in effect until I notify Papago Buttes Pediatric Center to terminate or change this authorization.

Patient Name (Print Legibly): _____

Patient Signature: _____ Date: _____

Patient Cell Phone: _____ Patient E-Mail:_____