Center For Pediatric Medicine *Our Family Caring For Yours*

Patient Authorization Form

Patient Name: _____ DOB: _____

This is to certify that I am 18 years of age or older and I authorize Center for Pediatric Medicine to share all of my protected health information (PHI) with my legal guardian(s)

Check One Option: ☐ Yes or ☐ No

Patient Portal

This is to certify that I am 18 years of age or older and I authorize Center for Pediatric Medicine to share all of my protected health information (PHI) with my legal guardian(s) through online portal services*. We assure all information is encrypted and stored securely.*

Check One Option: ☐ Yes or ☐ No

_____ _____
(Name of Parent/Legal Guardian) (Relationship to Patient)

_____ _____
(Name of Parent/Legal Guardian) (Relationship to Patient)

This authorization will expire on: _____ (Expiration Date or Defined Event).

_____ _____
(Patient Signature) (Today's Date)