Young Adult (18 Years +) Release & Consent Form

I, _____, DOB _____, give Woodbridge Pediatrics permission to discuss the following information about my health with the following individuals. I understand that I may revoke this permission at any time in writing.

1. Name _____ , Relationship: _____

2. Name _____ , Relationship: _____

3. Name _____ , Relationship: _____

Type of Healthcare Information	OKAY TO SHARE Information	NOT OKAY TO SHARE Information	ASK ME FIRST
Anything & Everything about my healthcare			
Routine Care (Appointments, Strep Tests, Flu Results, Non-Confidential Labs, RX Refills, etc.) Not related to Categories below			
Mental Health & Care			
Drugs/Alcohol			
Sexual Orientation/ Gender Identity			
Sexual Health/ Sexually Transmitted Infections/ Birth Control			
Pregnancy			

I have been presented with a copy of Woodbridge Pediatrics "Notice of Privacy Policies" and understand that my personal health information will be handled in accordance with these directives.

I understand that the release and/or transfer of my medical records to camps, colleges, or any third parties, will only be allowed with my written authorization.

I understand by signing below, I certify that I have read and understand the Eighteen Year+ Release & Consent form, and accept the conditions and terms. I further certify that I am the patient, or duly authorized representative.

_____ _____ _____

Patient Signature Date Patient Phone #

_____ _____ _____

Woodbridge Pediatrics Witness Date Patient Email Address