NORTHERN LIGHTS PEDIATRIC & ADOLESCENT MEDICINE

Consent Form to Verbally Release Health Information

- *Patients who are 18 years or older and Emancipated Minors*
- *Minors receiving treatment for mental health issues, chemical dependency, family planning or sexually transmitted disease.*

Expiration of this Consent – this consent will end one (1) year from the date the form was signed unless you indicate an earlier date or event here.

Patient Information:

First Name: _____ Last Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: ____ Zip: _____
Your Cell/Daytime Phone: _____ Your Email Address: _____

Contact Information – Who we can talk to?

I give permission for Northern Lights Pediatrics to talk to the following people:

1. First Name: _____ Last Name: _____ about the information indicated below.
   The person can be reached at: Daytime Phone: _____ Evening Phone: _____
   Relationship to you, the Patient: _____

2. First Name: _____ Last Name: _____ about the information indicated below.
   The person can be reached at: Daytime Phone: _____ Evening Phone: _____
   Relationship to you, the Patient: _____

Indicate the information that you are authorizing us to verbally discuss with the people listed above.

CHECK (√s) all that apply.

____ Specific dates/years of treatment _____
____ All health information **OR**

____ Medications	____ Chemical dependency or alcohol related care
____ Immunizations	____ Birth control, family planning, or pregnancy
____ Health/Behavioral Care	____ Sexually transmitted disease (STD) care
____ Billing records	____ Laboratory results

____ Other information or instructions _____
_____

Authorization:

Patient's Signature: _____ **Date:** _____

Continued Authorization: Initials: _____ Date: _____ Initials: _____ Date: _____

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FACT SHEET – PERMISSION OR AUTHORIZATION TO VERBALLY SHARE YOUR HEALTH INFORMAION

Patients who are 18 years or older & Emancipated Minors: ALL of your healthcare information is protected.

Minors: Treatment for mental health issues, chemical dependency, family planning or sexually transmitted disease (STD) is protected.

Your Privacy Is Important – Your health information is private and Minnesota law gives you control over your medical records.

Most health information needs your consent to be released or shared – We need your **written** consent to talk with your parents or other persons about your health information including your medications and billing. This written consent is also helpful when you are away at college or out of town.

- There are specific times that the law allows some health information to be released **without** your consent. An example is in a medical emergency or court order. Please ask if you have questions.

Copies of your Medical Record – If you want copies of your medical record, complete our separate "Release of Medical Information" form available at both of our clinic sites or on our web page www.NorthernLightsPediatrics.com. Feel free to call us with any questions.

You may stop this consent at any time – Just write to the clinic. You can mail or email this request to ma.staff@NorthernLightsPediatrics.com. If the clinic has already release the information based on previous consent, your request to stop will not work for that specific time frame.

If the information is sent to another person or place that you name, the information could be released by that person or place that receives it and may no longer be protected by federal or state privacy laws.

You will NOT be denied treatment or payment of your health care bills if you choose not to sign this authorization.