pediatric associates OF THE NORTHWEST

Teen Authorization to Discuss Protected Health Information with Parent(s) and or Guardian(s)

Patient Name (please print clearly): _____ **Date of Birth:** _____

Phone Number: _____ **Current Age:** _____

Your medical information has different protections under Oregon law. Until you are 18 years of age, your general medical information will be shared with your Parent(s) and/or Guardian(s) unless you have other valid legal documentation. Below, you get to choose what protected health information is shared based on your age.

I DO authorize Pediatric Associates of the NW to discuss the following protected health information with those parent(s) and/or guardian(s) listed below.

Select your choice(s). Only the information checked will be discussed.

_____ Birth control (any age)

_____ Mental health (age ≥ 14)

_____ Drug and/or alcohol use (age ≥ 14)

_____ Sexual health including sexually transmitted diseases/ HIV/AIDS (any age)

1. Name: _____ Relationship to patient: _____

   Phone Number: _____

2. Name: _____ Relationship to patient: _____

   Phone Number: _____

This authorization is valid for one year and may be revoked by the patient (verbally or in writing) at any time prior to one year. To revoke this authorization, please send a written statement to Medical Records at Pediatric Associates of the NW, 2701 NW Vaughn St, Suite 360, Portland, OR 97210 and state you are revoking authorization. Any use or disclosure already made with your permission cannot be undone.

_____ _____

Signature of Patient **Date**

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