MINOR DISCLOSURE FORM

Medical Information Disclosure for Minors 14 & Older- PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE

Patient Name:	DOB:
Mobile Phone:	Email:

Release Details

I understand as a patient age 14 or older that my medical information will no longer automatically be shared with my parents/legal guardians. I hereby authorize Coastal Pediatrics, LLC, it's representatives, physicians, and staff to share non-sensitive medical and financial information with the following individual(s).

___ At this time, I do not give authorization for my medical information to be discussed with anyone other than myself.

___ I give authorization to the providers and staff of Coastal Pediatrics, LLC to discuss my medical information with the following individuals.

Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone:

If applicable, I also give permission for "Sensitive Protected Health Information" which includes mental health, substance abuse, sexual health, sexually transmitted diseases/AIDS/HIV testing and results.

___ At this time, I do not give authorization for my medical information to be discussed with anyone other than myself.

___ I give authorization to the providers and staff of Coastal Pediatrics, LLC to discuss my medical information with the following individuals.

Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone:

I fully understand and accept the terms of this consent. I understand that I may revoke this consent at any time, and that I must notify Coastal Pediatrics, LLC in writing.

Patient Signature: _____ Date: _____

Witness: _____