

Consent To Communicate For patients 18 years of age and older 2025

First Name MI DOB ____/____/____ Patient Last Name

Patient Phone Number

Patient Email Address

This form is for patients 18 years or older. Pediatric Mobile Care encourages all patients, regardless of age, to have a trusted adult (usually a parent or former legal guardian) to participate in your clinic visits to assist with providing a full picture of your past medical history. It is Pediatric Mobile Care's policy to have the parent accompany the patient to the exam room whenever they are present unless the patient objects. It is also Pediatric Mobile Care policy to have the patient and clinician share, as appropriate, in the decision about who will be present during your visit. Patients at the age of 18 years must grant permission for others to partake in their health care by identifying who can receive information about their health.

Authorization for Release and Receipt of Medical and Other Information

I authorize Pediatric Mobile Care to use or disclose my medical information to the parent, former legal guardian, or other adult noted below in the following ways:

FULL ACCESS: (Includes Patient Portal Access)

Access to the Patient Portal (where you can view your past and current health information, office visits, lab or xray results, immunizations, and view future appointments, including all the options below) from our electronic medical records system.

LIMITED ACCESS – CHECK ALL THAT APPLY: (Does NOT Include Patient Portal Access)

- ☐ Verbal and Written Disclosures related to Mental Health (including diagnoses, appointments, and medications)
- ☐ Verbal and Written Disclosures related to Substance Use (including diagnoses, appointments, and medications) Verbal and Written Disclosures related to STIs, Pregnancy Information and Testing.
- ☐ Verbal Communication relating to routine appointments. Request and pick up prescription refills.
- ☐ Other: _____

I understand that Pediatric Mobile Care will not condition treatment on whether I sign this authorization. I understand that I am signing this form voluntarily and that I may revoke this authorization at any time by notifying Pediatric Mobile Care in writing at contact@pedsmobilecare.com. This release will automatically expire in 24 months. I also understand that if I choose to revoke this release prior to its expiration, it will not affect any information previously authorized and released by Pediatric Mobile Care. A copy of this form is as valid as the original.

I hereby authorize _____ (list name(s) of authorized person(s)) to share in my healthcare as outlined above. _____

Patient's Signature Date

- ☐ **Check this box ONLY if you do not want any information released.**
