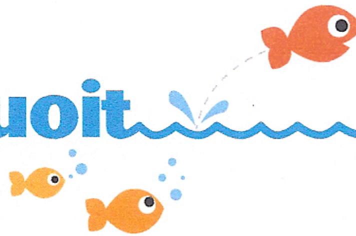
Irondequoit Pediatrics

Exceptional Care—
every step of the way.



irondequoitpediatrics.com

Teen Patient Authorization

Authorization to Discuss & Disclose Information to Others

1. By signing below, I authorize Irondequoit Pediatrics to discuss my medical history, care, appointments, prescriptions, referrals and lab results with the people I have listed below.
2. This authorization is valid until I reach the "Age of Majority" or I change, cancel, or update this authorization by completing a new form or by notifying this office in writing.
3. I understand that the signing of this form is voluntary and that Irondequoit Pediatrics has Privacy Policies in place to protect my rights.
4. I give permission to Irondequoit Pediatrics to leave a message on the answering machine/voice mail at the following phone number ___________

The people who are authorized to discuss my medical care are:

☐ Mother ____

☐ Father ____

☐ Other ____

The information that may discussed includes:

☐ My complete medical records INCLUDING sexual activity information, drug and alcohol information and treatment, mental health information and treatment, and STD/HIV information

☐ My complete medical records EXCLUDING sexual activity information, drug and alcohol information and treatment, mental health information and treatment, and STD/HIV information

☐ Exclude other information as described below:

____

____

Printed Patient Name:____

Patient Signature:____

Date of Birth:____

Date Signed:____

Witnessed by:____

Address. 485 Titus Avenue, Suite F, Rochester, NY 14617 Ph. 585-266-0310 Fx. 585.266.9207