FEDERAL WAY NATUROPATHY
Rooted in Your Well Being

18 & Older Annual HIPAA Release and Consent Form

I understand and acknowledge that by being 18 years of age or older, my parents and/or guardians no longer have access to my medical records, personal information, providers, or appointment status without my specific written consent, under Federal and State Notice of Privacy Practices regulations. Federal Way Naturopathy may not speak with my parents and/or guardians to schedule appointments, fill or refill prescriptions, or release personal and/or medical information to my parents without my written consent as indicated in this document.

_____**I DO NOT** grant access to my parents and/or guardians. **No medical record information, personal information or appointment information may be discussed or released.** I understand that I will schedule all of my appointments with Federal Way Naturopathy and contact Federal Way Naturopathy to update my personal information and/or request prescriptions and/or prescription refills.

_____**I DO WISH TO** grant my below listed parents and/or guardians' access to my healthcare providers and/or medical information as follows:

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Federal Way Naturopathy to schedule appointments, request prescriptions and/or prescription refills, discuss my healthcare, and access my complete medical record. **I understand this gives the listed parents and/or guardians full access to my Protected Health Information (PHI), as outlined in the Health Insurance Portability and Accountability Act (HIPAA).**

I understand that my records may contain information regarding the diagnosis and/or treatment of HIV/AIDS, sexually transmitted infections, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE The following information from the records released:

☐ HIV/AIDS ☐ Sexually transmitted infection ☐ Psychiatric disorders/mental health ☐ Drug/alcohol use

_____I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Federal Way Naturopathy for the **sole purpose of scheduling an appointment on my behalf**. NO access to my medical record, personal information, or information regarding my care may be provided or disclosed.

_____I give the above named individual(s) permission **to only request refills and pick up my prescriptions on my behalf.** NO access to my medical record, personal information, or my care may not be provided or disclosed.

_____ _____
Patient Printed Name Patient Birth Date

_____ _____
Patient Signature HIPAA Signature Date

This consent is valid for one year from the date signed. I understand that I have the right to withdraw my signed consent at any time by providing Federal Way Naturopathy with written notice indicating the changes in access.

I understand that this consent has no impact on whether or not I am covered under my parent/guardian's healthcare plan. Charges for my services are still billable to my parent/guardian's healthcare plan without their access to my PHI.