



Release of Information to Parent / Guardian FOR ADULT PATIENTS (18 YEARS OF AGE OR OLDER)

I, _____, authorize Girls to Women Health and Wellness to discuss/release the following protected health information to my parent(s)/guardian, named below, whether by phone, email or regular mail, as follows: (please check one only)

Any and all protected health information (this may include sexual health, mental health and HIV/AIDS information) pertaining to the medical care I received at or through Girls to Women Health and Wellness

Specific medical condition(s) (please state): _____

Medical care I received at or through Girls to Women Health and Wellness during the following dates:

_____ to _____

I authorize this information to be released to: _____ and/or _____
Print name of parent/guardian Print name of parent/guardian

This authorization is to be in effect until such time as I revoke it in writing.

Patient Name (print) (adult patients only)

Patient Signature (adult patients only)

____/____/____
Date

Witness Name (print)

Witness Signature

____/____/____
Date