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TEEN CONSENT FORM

THIS FORM IS TO BE FILLED OUT BY PATIENT.

I give permission to Riverside Pediatrics to discuss:

_______ **MY ENTIRE HEALTH RECORD,** which includes all office visits, emergency records (ED, college healthcare, urgent care centers, etc.), immunizations records, lab reports, radiology results, (x-rays, MRI's, CT scans), billing and insurance information.

With____, ________________________________
Name of person(s) Relationship

_______ **NONE OF INFORMATION** with someone other than me.

Patient Portal Access:

_______ **ONLY PATIENT ACCESS** (No one but you may access your portal)
_______ Parent full access **WITH PATIENT** (You have portal; parent has unlimited access)
_______ Parent full access **WITHOUT PATIENT** (You have no portal; parent has unlimited access)

____ ____
Patient email address Patient cell phone

____ ____
Parent Email address Parent cell phone

I understand that Riverside Pediatrics is happy to have me as a patient for sick and for checkups if I maintain a regular check up schedule. I understand that, eventually, I will move on to a doctor who treats adults, and when I do, I will inform Riverside Pediatrics so that I may have my records transferred to my adult doctor.

Signature____ Date____________________