Patient Responsibility Agreement
Over 18 HIPAA Release and Consent

Patient Name: **Chart #:**

I understand and acknowledge that, as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, appointment or financial status without my specific written permission. Jacksonville University School of Orthodontics (JUSO) will not speak with my parents, permit my parents to schedule appointments, provide medical information or allow access to my online account to my parents unless in accordance with this document.

I wish to grant my parents and/or guardians access to my healthcare providers, medical or financial information as follows:
(Select only ONE option and initial).
PRINT THE NAMES BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF:

____
(Print name of parent or guardian and indicate the relationship)

____
(Print name of parent or guardian and indicate the relationship)

___ I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact my orthodontist or any member of the staff at JUSO to schedule appointments, discuss my treatment, access my medical records or discuss my financial account. **THEY HAVE NO RESTRICTIONS.**

___ I give the above named individual(s) permission to contact my orthodontist or any staff member at JUSO to discuss my care and schedule appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL OR FINANCIAL RECORDS.**

___ I give the above named individual(s) permission to contact my orthodontist or any staff member at JUSO to discuss schedule appointments only. **APPOINTMENTS ONLY ACCESS.**

___ I give the above named individual(s) permission to contact my orthodontist or any staff member at JUSO to discuss my financial records only. **I DO NOT GRANT ACCESS TO MY MEDICAL, FINANCIAL OR APPOINTMENT RECORDS.**

___ **I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIAN. NO MEDICAL INFORMATION, RECORDS, APPOINTMENT OR FINANCIAL INFORMATION CAN BE RELEASED.**

This consent is valid as long as I am a patient in active treatment at JUSO. If I complete treatment and re-enter, I will need to sign a new form. I understand that I can withdraw consent at any time by providing JUSO with a written consent indicating the changes in access.

________________________________ ________________________________
Patient Name (Print Legibly) Date

________________________________ ________________________________
Patient Signature JUSO Witness