Dear Patient:

As you approach your 18th birthday and become a legal adult, please understand that your parents or legal guardians are no longer considered your legal representatives. Under state law and federal HIPAA regulations, you can consent to your own medical care and control your own medical records and information. This means that, with certain limited exceptions, we can no longer share your records or any medical information about you with your parents, or anyone else, without your written permission.

We do encourage you to continue to discuss, whenever possible, any health problems or concerns with your parents or legal guardians and to continue to seek their advice. If you would like us to be able to share your information with your parents, legal guardians or anyone else, we ask you to fill out and sign the enclosed Consent, Disclosure and Authorization form. Note that you can specify with whom we can share your information, and the type of information we may share. You are welcome, of course, to bring your parents or guardians with you when you visit us in the office.

You will also have access to your Patient Portal at Myadvocareonline.com. Through the portal, you can see medical information from your chart, including lab and test results, and ask for appointments, referrals and refills of prescriptions. You can obtain a username and password for your portal through the portal site or in our office. As with your chart, you can give your parents or legal guardians access to part of or your entire portal. We have also enclosed an authorization form for this purpose.

Please complete and sign the attached authorization forms and return it to us prior to your 18th birthday or as soon as possible thereafter.

Sincerely,
Your Advocare Providers

advocare

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION/ RESTRICTION OF PHI

Patient Name: _____ **Date of Birth:** _____

Person Authorized to Receive Information:
By signing this authorization, I authorize **Advocare** _____ (Care Center Name) to use and/or disclose certain protected health information (PHI) they have about me to the following person/ entity(s):

_____
Name of person or entity/ relationship

_____
Name of person or entity / relationship

I hereby authorize the release of the following to the person/entity(s) listed above: *(check all that apply)*

- □ **My Complete health record** (which includes info of ALL PHI check boxes below)

□ History and Physical Exams	□ Appointment and Visit Notes
□ Lab Report	□ X-Ray Report
□ Consultation Report	□ Prescription/ Pharmacy Records
□ Mental Health Records	□ Alcohol/ Drug Abuse Treatment
□ Communicable disease	□ HIV/ AIDS (inc. testing related info)
□ My (patient) personal Contact information	□ Any Occupation/ Employer Information
□ My (pt.) spouse's Contact information	□ Hospital notes

- □ Other (please specify): _____

The information will be used or disclosed for the following purpose: *(check all that apply)*

□ Continuing Care	□ Research	□ Workers Compensation
□ Legal	□ Marketing	□ Insurance Company
□ School	□ Second Opinion	

- □ Other: _____

Expiration Date of Authorization:
This authorization will expire on _____ (date or defined event). If no expiration is provided this authorization will remain in effect unless revoked or terminated by the patient or patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to the Privacy Officer or other authorized representation in our office.

By signing below, I acknowledge that I have read and understand:

- That when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- The care center may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.
- That I do not have to sign this authorization in order to receive treatment and by signing below,
- A photocopy of this authorization will be considered as valid as the original (copy to be provided upon request.

Signed by: _____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Print Name of Patient or Legal Guardian **Relationship to Patient**