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Amherst Pediatric Associates
Consent Form to Release Information to Parents
(For patients 18 years and older)

☐ I authorize Amherst Pediatric Associates and its staff, to release information pertaining to my care to my parent(s) and/or guardian(s).

☐ I **DO NOT** authorize Amherst Pediatric Associates and its staff to release information pertaining to my care to my parent(s) and/or guardian(s).

I further understand that Amherst Pediatrics' and its staff will abide by my decision unless they determine that withholding my Protected Health Information form my parent(s) and/or guardian(s) might be health or life threatening.

______________________________ ______________________________
Patient Signature Witness

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Date

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