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HIPAA AUTHORIZATION FOR
Adult Patients (over 18 years of age):

Date: _____

Patient's Name: _____
(please clearly print)

Date of birth: _____

I allow Mendon Pediatrics, PLLC, to share information regarding the following medical issues **with my parent(s) or guardian**: _____.
Print names

please check:

- □ mental health issues
- □ referrals local and out of area
- □ non confidential labs
- □ other _____
- □ prescription refills
- □ non confidential x rays
- □ specialist information

**I understand that any medical issues of a confidential nature, ie., sexual, drug, alcohol, etc. will not be discussed with anyone other than myself.

I allow Mendon Pediatrics, PLLC, to share vaccine administration information with the New York State Immunization Registry (NYSIIS). ____ Yes ____ No

_____
Signature of patient