Richmond Pediatric Associates
Medical Care after Age 18 Agreement

Date ___/___/___

PATIENT NAME DATE OF BIRTH

Last First M D Y

Dear Parents and Patients,
We are pleased to offer you the option to continue your medical care at Richmond Pediatric Associates after the age of 18 and/or after you graduation from high school. If you choose to continue you care with RPA these guidelines will apply:

1.) Once you reach your eighteenth birthday, you are legally considered an adult in regard to medical decisions and medical care, even if you are covered by a parent's insurance plan. Without your written consent, our doctors cannot discuss any aspects of your care with your parents. You will have to initiate all contact with us if there are questions or concerns. Alternatively, you may sign an "Age 18 Consent to Release Patient Information" if you would like a parent or guardian to communicate with us on your behalf.

2.) Since college students spend about half of the year away at school and the other half in their home town, our physicians will be happy to see you for medical care when you are local. We cannot help you with acute medical problems from a distance and encourage you to use your student health service resources. We will not be able to prescribe medications over the phone or diagnose new medical problems without seeing you in person.

3.) If you are away at school and plan to continue medications we have prescribed for the treatment of chronic problems such as asthma, allergies ADHD, etc., we must see you in person periodically if we are to renew these prescriptions. If a patient requires close monitoring, we may ask that you see a physician regularly near your school.

4.) Although we provide general medical care, we encourage our female patients to see a local gynecologist prior to going away to school.

5.) If you do stay with our practice after age 18, we will expect you to transfer you records and future care to an internist and/or gynecologist before your 22nd birthday. Once you choose and internist, please request your records and allow two weeks for preparation. Each patient over eighteen must sign a specific records release form, and must retrieve their medical records in person, unless we have written permission for a parent or guardian to do so.

6.) If you plan to remain a patient of Richmond Pediatric Associates., please sign this agreement to indicate you understand and agree to the forgoing terms.

I have read and understand the conditions presented above in regard to remaining a patient.

I hereby choose to continue as a patient of Richmond Pediatric Associates after my eighteenth birthday.

Patient Name Patient Signature

Cell Phone Number Email Address

Richmond Pediatric Associates
Medical Care after Age 18 Agreement
To Release Patient Information

Patient Name **Date of Birth**

LAST FIRST M D Y

WHO MAY ACCESS YOUR HEALTH CARE RECORDS

I give the following adults permission to receive my health records including but not limited to ***x-rays, immunizations, lab results, prescriptions, financial information or to act on my behalf in my absence.***

NAME (PERSON AUTHORIZED TO ACCESS RECORDS)	PHONE	RELATIONSHIP TO PATIENT
NAME (PERSON AUTHORIZED TO ACCESS RECORDS)	PHONE	RELATIONSHIP TO PATIENT
NAME (PERSON AUTHORIZED TO ACCESS RECORDS)	PHONE	RELATIONSHIP TO PATIENT
NAME (PERSON AUTHORIZED TO ACCESS RECORDS)	PHONE	RELATIONSHIP TO PATIENT

THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS THIS SECTION IS CHECKED OFF AND SIGNED.

PATIENT SIGNATURE DATE

Psychiatric Records Yes ___ No ___ _____

Sexual Records Yes ___ No ___ _____

Drug and Alcohol Records Yes ___ No ___ _____

- I understand that if the person or the entity that receives this information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
- I understand that there may be medical records form another doctor or another medical facility in my chart.
- I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for treatment.
- I understand I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

These authorizations are valid unless and until they are revoked, in writing, and presented to the records office of Richmond Pediatric Associates.

PATIENT SIGNATURE DATE