
**Persons whom you will allow access to your medical records
per the HIPPA Privacy Act**

If you are a minor (under the age of 18yrs.)

**Does granting your permission above include discussing sexual
activity and STD testing?**

Yes _____ No _____

Sign _____ Witness _____

(You do not need to list doctors and insurance companies)

Name _____ Home Phone _____

Address _____ Relationship _____

Name _____ Home Phone _____

Address _____ Relationship _____

Name _____ Home Phone _____

Address _____ Relationship _____

Name _____ Home Phone _____

Address _____ Relationship _____

Signature _____ Date _____