Pediatric Partners of the Southwest (PPSW)

TEEN PATIENT REGISTRATION FORM (13+ year old)

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

Patient Address:_____ **City**:_____ **State**:_____ **Zip**: _____

Email: _____ **Cell Phone**: _____

How can we reach you? ***(Circle one):*** CELL PHONE EMAIL

PPSW has permission to send text messages to my cell phone: ***(Circle one)*** YES NO

PPSW has permission to leave detailed medically related messages at: ***(Circle one)*** CELL PHONE EMAIL

Emergency Contact: _____ **Relationship to me**: _____ **Contact Number**: _____

Patient Signature:_____ **Date**:_____

Once a PPSW patient turns 18 years of age we are no longer able to discuss any medical issue with their parent(s)/guardian(s) without patient permission. If you would like us to be able to discuss medical issues with your parent(s)/guardian(s), please complete the area below:

18+ YEAR OLD CONSENT TO SHARE HEALTHCARE/MEDICAL INFORMATION

I give Pediatric Partners of the Southwest permission to release my healthcare/medical information to:

Name:_____ **Relationship to me**: _____

Address: _____**City**:_____ **State**:_____ **Zip**:_____

Home Phone: _____**Cell phone**:_____ **Email:** _____

THIS AUTHORIZATION IS FOR THE FOLLOWING: (Check all that apply)

☐ **ALL** Healthcare/medical information

☐ **Specific Healthcare/medical information**: _____

☐ **Other**:_____

Definition: Sexually Transmitted Infection (STI) as defined by law RCW 70.54 et seq., includes herpes, herpes simplex, human papilloma virus (HPV), wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and Gonorrhea.

☐ **YES** ☐ **NO** I authorize the release of my STI results, HIV/AIDS testing, pregnancy testing, whether negative or positive, to the person named above. I understand that the person named above will be notified that I must give specific, written permission, before disclosure of these test results to anyone.

☐ **YES** ☐ **NO** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person named above.

☐ **YES** ☐ **NO** I authorize parent/guardian to access all billing and insurance related information. If you decline to authorize parent/guardian permissions account balances will be patient responsibility.

Patient Signature:_____ Date: _____