WILLIAM T. LIN, MD, PA
2821 E. PRESIDENT GEORGE BUSH HWY, SUITE 101
RICHARDSON, TEXAS 75082
972-235-9444
WWW.DRWILLIAMLIN.COM

Over 18 HIPAA Release and Consent Form(Pg.1)

I understand and acknowledge that as of my 18th birthday, my parents/guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Dr. Lin and his Staff will not speak with my parents/guardians to schedule appointments or release medical information to my parents without my written consent in accordance with this document. This Authorization will be valid until my 22nd birthday.

_____ (init) I WISH TO grant my parents/guardians access to my medical information as follows:

_____

(print name of parent/guardian; indicate his/her relationship to you)

_____

(print name of parent/guardian; indicate his/her relationship to you)

I give the above-named individuals permission to act on my behalf. I understand that they may contact Dr. Lin and his Staff to schedule appointments, discuss my healthcare, and access my medical records.

Please specify if you wish to include the following (by initialing):

_____ Alcohol/Drug Treatment
_____ Mental Health Info
_____ Sexually Transmitted Diseases (HIV,etc.)
_____ Pregnancy/Sexual Activity

I understand and agree that:

1. The purpose is provided above so that I can make a decision as to whether to allow the release of information.
2. I do not have to sign this authorization in order to receive treatment.
3. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule or other law protecting its confidentiality.
4. I have the right to revoke this authorization at any time with a written notice to William T. Lin, MD, PA, except to the extent that the office has acted in reliance upon it.

_____ _____

Signature Printed Name

_____ _____ _____

Cell phone Email Date

WILLIAM T. LIN, MD, PA
2821 E. PRESIDENT GEORGE BUSH HWY, SUITE 101
RICHARDSON, TEXAS 75082
972-235-9444
WWW.DRWILLIAMLIN.COM

Over 18 Consent (Page 2)

Appointment Reminder Consent (initial one): Our office texts the patient or parent/guardian 48 hours to remind them of their appointment.

Initial only one:
_____ Text me at my cell phone
_____ Text my mom/dad/guardian at their cell phone: _____

If the receiver does not reply to the text, we will call to remind you of your appointment:
Initial all that apply:
_____ Call me on my cell phone
_____ Call my mom/dad/guardian on their cell phone: _____

Financial Responsibility: Our office sends balances that are due to the responsible party by USPS, Text, and Email
Initial one:
_____ I am financially responsible. (circle all that apply)
Please send my balances to me by: text email USPS

_____ My parent/guardian is financially responsible. (circle all that apply)
Please send my balances to them by: text email USPS

Name of parent/guardian responsible: _____
Signature of parent/guardian responsible: _____

Missed or Failed Appointments:
Initial (required):
_____ I understand that if I miss an appointment or do not contact the office to reschedule the appointment, then I or my financially responsible party will be charged a $35.00 convenience fee.

_____ _____ _____
Signature Printed Name Date

Mailing Address:

_____ _____ _____ _____
Street Address City State Zip Code