Minor Authorization Form

The following form states that the below named individual(s) are authorized to bring my child to appointments while I am not present and to release protected health information to the **individual(s) named below**. I understand that the individual bringing my child to the appointment must be at least 18 years of age.

Name of Patient: _____Date of Birth_____
Name of Patient: _____Date of Birth: _____
Name of Patient: _____Date of Birth: _____
Address: _____
City: _____State: _____ Zip Code: _____

Please list any individuals in which you authorize for the above statement:
Example; sibling, grandparents, aunt, uncle, baby sitter etc.
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

Check the information to be released to above named individual:
_____ Financial Information
_____ Results from tests or x-rays
_____ Appointment Confirmation
_____ Consent/ Authorization for treatment / Healthcare Disclosure
_____ Other information: _____

Patient Rights;

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effect in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

By signing this document I agree that the above named persons are authorized to bring my child(ren) to appointments in my absence.

Signature: _____ Date: _____

*If you are not the parent or legal guardian we may need additional documentation.