FRESNO CHILDREN'S
MEDICAL GROUP
www.fresnochildrens.com

AUTHORIZATION FOR AGENT TO RECEIVE PROTECTED HEALTH INFORMATION OF A MINOR

Child's Name:_____ **Date of Birth:**_____

Child's Name:_____ **Date of Birth:**_____

Child's Name:_____ Date of Birth:_____

I hereby authorize the following adults:

_____ _____**(Relationship to minor)**

_____ _____**(Relationship to minor)**

_____ _____**(Relationship to** minor)

into whose care the minor has been entrusted, to receive protected health information pertaining to any physical exam findings, medical procedures, laboratory and radiological findings; and give consent for immunizations and treatments deemed advisable by a licensed physician and provided by that physician or under that physician's supervision, regardless of where treatment is provided.

This authorization is under the Health Insurance Portability and Accountability Act of 1996.

Signed_____ **Dated**_____

Print Name:_____ **Relationship to Minor:**_____

( ) This authorization is to be in effect from_____ **to**_____**.**

( ) This authorization is to remain in effect until revoked by the above signed.