



## 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.