



**AUTHORIZATION FOR AGENT TO RECEIVE
PROTECTED HEALTH INFORMATION OF A MINOR**

Child's Name: _____ Date of Birth: _____

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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.