

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**AUTHORIZATION OF PERSONS TO CONSENT FOR TREATMENT IN THE
ABSENCE OF PARENT/GUARDIAN**

This form is to be completed by the PARENT or GUARDIAN of a minor (under age 18) patient, if the PARENT/GUARDIAN wishes to authorize other individuals (such as a grandparent, aunt/uncle or family friend) to accompany the minor patient to appointments and consent to treatment of the minor patient. When the PATIENT reaches age 18 or if the PATIENT has been legally emancipated, the PARENT/GUARDIAN no longer has the right to consent to treatment or to authorize anyone else to do so. **Notwithstanding the foregoing, in the Commonwealth of Pennsylvania, a medical professional may discuss a minor Patient's protected health information with a non-Authorized party if, in their professional judgment, it is vital to the care of the minor Patient and no Authorized party is present.**

SECTION A: PATIENT INFORMATION

[Child/Children]

Name(s): _____

SECTION B: INDIVIDUAL AUTHORIZING ON BEHALF OF PATIENT

[Biological Parents OR Legal Guardians]

Name: _____ Relationship to Patient: _____

[NOTE: If there is a custody agreement, this individual must be the person who has healthcare decision-making rights for each child listed above.]

OTHER PARENT/GUARDIAN:

Name: _____ Relationship to Patient: _____

SECTION C: INDIVIDUAL ALLOWED TO BRING CHILDREN

By completing and signing this form, you confirm and **authorize the disclosure of protected health information (PHI) of the minor patient** and/or **authorize the accompaniment for treatment and consent for treatment of the minor patient(s)** listed above to the individuals listed below:

**Anyone birth parent is authorizing to bring patient to appointment. PHI Disclosure*

*Accompaniment/
Consent to Treatment*

Individual's Name: _____

Relationship to Patient: _____

Initial Here

Initial Here

Individual's Name: _____

Relationship to Patient: _____

Initial Here

Initial Here

Individual's Name: _____

Relationship to Patient: _____

Initial Here

Initial Here

Signature of Birth /Biological /Court Ordered Guardian /Individual:

Sign: _____

Date: _____