

HIPAA Authorization Form for Parents

HIPAA AUTHORIZATION FORM FOR PARENTS

Child's full name: _____ Child's date of birth: _____ dd / mm / yyyy

Child's age: _____

Child's current address:

Father's full name: _____

Father's current address:

Father's contact information: _____ Mother's full name: _____

Mother's current address:

Mother's contact information: _____

We understand that under the Health Insurance Portability & Accountability Act of 1996 [HIPAA], we have certain rights to privacy regarding my minor child's protected health information. We understand that this information can and will be used to: • Conduct, plan, and direct our child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly • Obtain payment from an insurance company • Conduct normal healthcare operations such as quality assessments and physician certifications • Remind us of upcoming appointments, treatment options, or alternatives

Print Name: _____ Relationship: _____

Father's signature:

Date signed: _____ dd / mm / yyyy

Mother's signature:

Date signed: _____ dd / mm / yyyy