

# Minor Child HIPAA Privacy Authorization Form

**Instructions:** This form is used to authorize the disclosure of protected health information (PHI) regarding a minor child in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

## 1. Minor Child's Information

Child's Full Name:

Date of Birth:

Address:

## 2. Parent / Legal Guardian Information

Parent/Guardian Full Name:

Relationship to Child:

Phone Number:

Email Address:

## 3. Authorized Entities / Individuals

I hereby authorize the following healthcare provider(s) or organization(s) to release the minor child's protected health information:

Disclosing Provider/Facility Name:

I authorize the information to be released to the following individual(s) or organization(s):

Recipient Name/Organization:

Relationship to Child / Purpose:

## 4. Description of Information to be Disclosed

Please specify the health information you authorize to be released (e.g., "All medical records", "Immunization records only", "Dental records"):

Information to be Disclosed:

## 5. Expiration of Authorization

This authorization will expire on the following date or upon the occurrence of the following event:

Expiration Date or Event:

## 6. Acknowledgment and Signature

By signing below, I understand that this authorization is voluntary. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

Printed Name of Parent/Guardian:

Signature of Parent/Guardian: \_\_\_\_\_

Date: