Children First Pediatrics, PC
Pediatric and Adolescent Medicine

Patient Authorization Form

I have received a copy of the Notice of Privacy Practices for Children First Pediatrics. I understand my rights and how my medical information will be used. I further understand that I can authorize other parties to have access to my medical information that is not included in the Notice of Privacy Practices. I acknowledge that as a pediatrician's office, there are other people that I will want to have access to my child/children's medical information in case I am not available or do not have the information they need. This form allows me to authorize these individuals with the right to my child's medical information. If there are any individuals listed below who should only have limited access to the information, I must document that next to their name. Otherwise, the individuals listed below can have full access to any of my children's medical information.

I hereby authorize you to use or disclose protected health information to the following people who care for my child/children and would need access to this information should I not be present at the time of a visit or during a phone conversation. I understand that any of the people listed below may be taken off this list by sending a written request to the Privacy Officer of the practice. I also understand that I may add people to this list my submitting a written request to the Privacy Officer.

Authorized Parties (including parent):

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

The authorization shall remain in effect from the date signed below. I will contact the practice every 36 months to update the authorizations on record.

Patient Name:_____ DOB:_____ AGE:___

Signature of Parent/Legal Guardian_____ Date:_____