# Minors Accompanied By Someone Other Than Parent/Legal Guardian

The purpose of this form is to identify individuals you would allow to bring your child for visits to Salud Pediatrics and also authorize the disclosure of information during visits. This form will be valid until the patient turns 18 or otherwise revoked. I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Name of Child: _____ Today's Date: _____

Name of Child: _____ Today's Date: _____

**I hereby authorize the protected health information regarding the above-named patient to be exchanged between Salud Pediatrics and the individuals listed above for the following purposes**: Allowing the above-named patient to accompany my child for his/her appointment and to receive information directly relevant to such individuals' presence at my child's appointment. I understand that sensitive information may be shared including Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Disease, Pregnancy and Birth Control.

Name: _____ Relationship: _____
Please Print Name

Name: _____ Relationship: _____
Please Print Name

Parent/Legal Guardian Signature: _____