

HIPAA Parental Authorization for Minors' Medical Records

Minor's Information

Full Name of Minor

Date of Birth

Address

Parent/Guardian Information

Full Name of Parent/Guardian

Relationship to Minor

Phone Number

Authorization

Healthcare Provider/Facility to Release Records

Purpose of Authorization

Description of Records to be Released

Person/Facility to Receive Records

Expiration & Rights

Expiration Date or Event

Special Instructions or Restrictions

Parent/Guardian Signature

Date