Glens Falls Pediatric Associates
Pediatric Associates of Saratoga
HIPAA Privacy Information
Authorization for Treatment of a Minor when a Parent is Not Present

Patient Name _____ DOB: _____

Parent/Guardian _____ Relationship_____

How may we communicate information to you (PLEASE CHECK ALL THAT APPLY).

Appointment Information

On home phone □ #_____
On cell phone □ #_____
On office phone □ #_____
Message with family member at home phone □

Medical Information

On home phone □ #_____
On cell phone □ #_____
On office phone □ #_____
Message with family member at home phone □

As a parent of the above named minor, I give permission for staff at Glens Falls Pediatrics Consultants/Pediatric Associates of Saratoga to discuss my child's medical care/treatment with any of the following:

_____ Relationship to patient _____,
_____ Relationship to patient _____,
_____ Relationship to patient _____,

I/We the undersigned parents(s)/legal guardian(s), authorize the following to bring the above listed patient to Glens Falls Pediatrics for healthcare in my absence **(**NOT TO BE USED FOR VACCINES):**

_____ Relationship to patient _____,
_____ Relationship to patient _____,
_____ Relationship to patient _____,
_____ Relationship to patient _____,

Specific HIPPA Instructions:

This consent shall remain in effect until revoked, in writing, by parents(s) or legal guardian(s), or until the child may legally consent for him or herself.

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of witness Date