

**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     # \_\_\_\_\_  
Texting on cell     # \_\_\_\_\_  
On office phone     # \_\_\_\_\_

Medical Information

On home phone     # \_\_\_\_\_  
On cell phone     # \_\_\_\_\_  
Texting on cell     # \_\_\_\_\_  
On office phone     # \_\_\_\_\_

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 authorization to consent for vaccines at visit -- form available online at [www.gfpeds.com](http://www.gfpeds.com)\*\***

\_\_\_\_\_ Relationship to patient \_\_\_\_\_,  
\_\_\_\_\_ Relationship to patient \_\_\_\_\_,  
\_\_\_\_\_ Relationship to patient \_\_\_\_\_,  
\_\_\_\_\_ Relationship to patient \_\_\_\_\_,

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 \_\_\_\_\_ PH# \_\_\_\_\_,  
\_\_\_\_\_ Relationship to patient \_\_\_\_\_ PH# \_\_\_\_\_,  
\_\_\_\_\_ Relationship to patient \_\_\_\_\_ PH# \_\_\_\_\_,

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