Glens Falls Pediatric Associates
Pediatric Associates of Saratoga

HIPPA Privacy Information
Authorization for Treatment of a Minor when a Parent is Not Present

Patient Name _____ DOB: _____

Parent/Guardian _____ Relationship_____

How would you like us to communicate (please check all that apply)

Appointment Information		**Medical Information**	
On home phone	□	On home phone	□
On cell phone	□	On cell phone	□
On office phone	□	On office phone	□
With family member	□	With family member	□
Via email	□	Via email	□

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 _____,

Special HIPPA Instructions: _____

_____

_____

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 _____,

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