MINOR CHILD'S CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)
(DO NOT USE FOR ADULT RECORDS)

MINOR CHILD ONLY

Medical Records Department (309) 449-4283

PATIENT (MINOR CHILD'S) NAME (please print): _____ **DATE OF BIRTH:** _____

PATIENT'S ADDRESS _____

The undersigned hereby authorizes **use or disclosure of the above named minor patient's Protected Health Information (PHI) described below.**

1. Hopedale Medical Complex (HMC), including Hopedale Hospital, Hopedale Nursing Home, Medical Arts Physicians, Hopedale Pharmacy, Hopedale Wellness Center, Hopedale Commons and all its entities/employees are authorized to *use or disclose Protected Health Information (PHI)* about the patient. "PHI" includes individually identifiable information and medical records relating to the patient's health, healthcare provider, billing, insurance and demographic information.

2. The following person (or class of persons) *are authorized to* ***receive disclosure*** **of (PHI)** about the patient:
   His/her/its name and address: (a) _____
   _____
   _____

   NOTE: IF BOTH PARENTS OF MINOR CHILD ARE NOT TO HAVE ACCESS TO THE CHILD'S MEDICAL INFORMATION YOU MUST INITIAL HERE AND PROVIDE HMC WITH A COPY OF SUPPORTING DOCUMENTATION (i.e. Order of Protection, divorce/custody order)!!!

   (b) **NO—DO NOT RELEASE CHILD'S PHI TO HIS/HER father/mother (circle) initial** _____
   (c) **List name/address of child's parent NOT to have access** _____

3. The specific medical records/PHI that should be disclosed are (please give dates of service if possible):

(a) All PHI (initial here) _____
(b) Only the following PHI: _____

NOTE: For hospital in-patients, HMC may release the patient's general condition (Good, Fair, etc.) to all persons inquiring (including family) unless you initial here: _____ **NO, DO NOT** DISCLOSE PATIENT'S CONDITION.

UNLESS YOU INITIAL HERE, ____ NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: **YES,** DISCLOSE THIS INFORMATION (initial here) _____

4. The undersigned understands that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. The undersigned may revoke this authorization by notifying Hopedale Medical Complex Medical Records Department or the Chief Operating Officer.
   However, the undersigned understands that any action already taken in reliance on this authorization cannot be reversed, and a revocation will not affect those actions. The undersigned understands that HMC may not condition its treatment of the patient on whether or not this authorization is signed.

6. This authorization **expires 6 years from today's date unless,** Patient wants authorization to expire sooner or upon some future event, indicate here: _____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. You agree to pay said invoice within 30 days.

THIS FORM MUST BE COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Patient (The person about whom the information relates)	Date of Patient's Signature	Date of Birth or Social Security Number

OR, if applicable –

_____	_____	_____
Signature of Guardian or Personal Representative of Patient	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual (c.s. POA, guardian, executor)

_____	_____
Witness	Date of Witness Signature