Advocate Medical Group

Inspiring medicine. Changing lives.

AUTHORIZATION FOR TREATMENT OF MINOR BY DELEGATED PERSONS

Patient Name_____ Date of Birth_____

I hereby authorize that the following person(s) have my permission to seek medical treatment (*) of the above-named minor child in my absence and that his/her protected health information (**) may be shared.

Person: _____ Telephone Number: _____

Relationship to Patient: _____

Person: _____ Telephone Number: _____

Relationship to Patient: _____

_____ Short-term authorization (30 days – held at reception desk)

_____ Long-term authorization (in effect until revoked in writing)

It is my responsibility to notify Advocate Medical Group of changes and to complete a new form.

I hereby authorize that the following person has my permission to seek follow up care in my absence.

Person: _____ Telephone Number: _____

Relationship to Patient: _____

It is my responsibility to notify Advocate Medical Group of changes and to complete a new form.

_____ _____ _____

Signature of Parent or Legal Guardian **Relationship to Patient** **Date**

* Medical treatment includes primary and specialty visits, routine radiology and laboratory tests, and immunizations.

** Protected health information includes but is not limited to test results, diagnosis, treatment and billing information. Highly confidential information will not be released unless the parent/legal guardian has also completed an Authorization for Release of Highly Confidential Health Information form. This information includes mental illness or developmental disability, psychotherapy notes, HIV or AIDS testing or treatment (including information regarding test ordering, performance or results, regardless if the results were positive or negative), sexually transmitted disease, substance abuse, abuse of an adult with a disability, sexual assault, child abuse or neglect, genetic testing.