AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

and

AUTHORIZATION OF PERSONS TO CONSENT FOR TREATMENT AND RECEIVE PROTECTED HEALTH INFORMATION IN THE ABSENCE OF PARENT/GUARDIAN

This Authorization is to be completed by the Parent/Guardian *unless* the Patient has reached the age of majority (18 years), the Patient is a legally emancipated minor, or the Patient was previously adjudicated legally incompetent but has now been deemed competent. When the Patient has reached the age of majority, is legally emancipated, or is deemed legally competent, the Parent/Guardian no longer has the right to consent to treatment, to authorize anyone else to consent for treatment or receive protected health information (PHI) on behalf of the Patient.

SECTION A: PATIENT FORMATION (If more than 1 patient in same family, please list ALL patients)

Name(s): _____

Address: _____ Telephone: _____

SECTION B: INDIVIDUAL AUTHORIZING ON BEHALF OF PATIENT(S) IDENTIFIED IN SECTION A ABOVE (IF APPLICABLE)

Name: _____ Relationship to Patient(s): _____

[NOTE: If there is a custody agreement, this individual must be the person who has healthcare decision-making rights for the child. BOTH Parents are authorized to consent for health care (medical/dental therapy) of minor patient in the absence of a court order removing 1 parent's rights.]

Check if address is the same as above: _____

If different: Address: _____

Telephone: _____ E-mail: _____

List *OTHER PARENT'S Name*

Name: _____ Relationship to Patient: _____

SECTION C: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

By 1) indicating by **CHECKMARK**, 2) **INITIALING** beside any such checkmark, and 3) signing this form, you are acknowledging that you have full and legal authority to **authorize the disclosure of protected health information of the patient and/or authorize the person authorized under Section C of this Authorization **** to consent for treatment or receive protected health information of individuals identified in Section A above in the absence of Parent/Guardian. You may check either or both boxes beside a person's name.

(PLEASE NOTE: Unless step-parents, grandparents, aunts, uncles, neighbors or others are named as legal guardian of the patient, you should include their names here if you would like for them to have access to the patient(s)' PHI or receive copies of the patient(s) PHI or to be able to accompany the patient(s) for treatment and consent to treatment.)

	Authorized to Receive PHI (Initials & Checkmarks)	Authorized to Accompany and Consent for treatment (Initials & Checkmarks)
Individual's Name: _____	☐ _____	☐ _____
Relationship to Patient: _____		
Individual's Address: _____		
Phone #: _____		
Individual's Name: _____	☐ _____	☐ _____
Relationship to Patient: _____		
Individual's Address: _____		
Phone#: _____		
Individual's Name: _____	☐ _____	☐ _____
Relationship to Patient: _____		
Individual's Address: _____		
Phone #: _____		
Individual's Name: _____	☐ _____	☐ _____
Relationship to Patient: _____		
Individual's Address: _____		
Phone #: _____		

You acknowledge that when you request a copy of Patient(s)' record, we may take up to five (5) business days to respond. There is a potential for information released pursuant to this authorization to be released to a third party and as a result no longer protected as permitted by law.

Signature of Individual Authorizing Disclosure of PHI and/or Authorization of Persons to Consent for Treatment and Receive PHI in the Absence of the Parent/Guardian:

_____ _____

Parent or Guardian name/signature (MUST MATCH information in SECTION B ABOVE)

Witness (Employee of this practice)

_____

Witness' Name and Job Title

Date: _____

[NOTE: **ONLY NOTARIZE IF** AUTHORIZATION FOR ANOTHER INDIVIDUAL TO CONSENT TO PATIENT(S)' TREATMENT is **completed OUTSIDE OF THE OFFICE.**]

Sworn before me this _____day of _____, _____, in the County of _____, State of _____.

_____ (seal)

Notary Public

_____ _____

State County

My commission expires _____

Expiration: This Authorization expires two (2) years from the date the patient reaches the Age of Majority, the Patient is legally emancipated or when the Patient is no longer adjudicated legally incompetent.

Right to Revoke: You have the right to revoke this Authorization at any time by giving us written notice of your revocation submitted to the Office Manager at Playtime Dental, 1145 Aspira Court, Mansfield, OH 44906. Please understand that revocation of this Authorization will not affect any action we take in reliance on this Authorization before we received your revocation and that we may decline to treat or to continue to treat Patient if you revoke this Authorization.

****NOTE: Some state laws may prohibit the delegation of the right to consent for a patient, unless in a durable power of attorney or in guardianship papers.**

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include completed Authorization in the Patient's chart.