MINDPATH HEALTH

Authorization for Disclosure of Minor Patient's Health Information to Parent(s)/Guardian(s)

Patient Information

Patient Name: _____

Date of Birth (mm/dd/yy): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Recipient of Health Information

I hereby authorize Mindpath Health, my treating provider(s), and its staff to disclose my health information to my parent(s) or guardian(s) named below:

(1) Parent/Guardian: _____

Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

(2) Parent/Guardian: _____

Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Purpose of Disclosure

The purpose of the disclosure of my health information is:

☐ Care Coordination ☐ Treatment Planning ☐ Legal
☐ Billing/Payment Activity ☐ Personal Use

☐ Other (Specify):

_____

Information to be Disclosed

I authorize the following information to be disclosed:

☐ All of my health information and records, including information about my appointments, prescription medications and billing/payment for my care

OR

☐ Only the following information (specify):

_____

I authorize the disclosure of the following specially protected health information *(check and initial all that apply):*

☐ Abortion
☐ Alcohol/drug treatment records
☐ Genetic test results
☐ HIV/AIDS test results
☐ Inpatient/residential mental health treatment information
☐ Pregnancy test results
☐ Sexually transmitted or other communicable diseases

Expiration and Revocation

This Authorization will expire on the date that is five (5) years from the date of my signature below.

I understand that I may revoke this Authorization at any time by notifying Mindpath Health in writing, except to the extent Mindpath Health has already taken action in reliance on this Authorization.

Signature

I have read this form and I understand and agree to its terms. I authorize Mindpath Health to disclose the information identified above.
I understand that Mindpath Health cannot condition my treatment, payment, enrollment or eligibility for benefits on my provision of this Authorization. I understand that information disclosed pursuant to this Authorization, except for alcohol/drug treatment records protected by 42 CFR Part 2, may be subject to redisclosure by the recipient and no longer protected by HIPAA. I understand that I have the right to receive a copy of this Authorization.

_____ _____
Patient Signature Date

_____ _____
Patient Name Patient Date of Birth