SPECIAL AUTHORIZATION FOR MINORS

SOURCE: __HIM_____

Release of Information fax: 205-383-1763

I, _____, hereby authorize and give my permission for
Patient name

_____, to have access to my medical records pertaining to:
Parent/guardian name

Check all that apply:

- ☐ Sexually transmitted diseases (STDs)
- ☐ Birth control
- ☐ Pregnancy
- ☐ AIDS/HIV testing
- ☐ Drug, alcohol or mental disorders

_____ _____ _____
Minor's signature Date of birth Date

Patient phone number _____

_____ _____
Witness signature Date

***Please note that if you are currently signed up for MyChart, results will be sent to that account, allowing your parent/guardian access to these results.**

This institution is an equal opportunity provider and employer.