VIP Midsouth, LLC

AUTHORIZATION TO COMMUNICATE MINOR'S HEALTH INFORMATION TO FAMILY AND OTHER INDIVIDUALS

PATIENT IDENTIFICATION

Name: _____

Date of Birth: _____

S.S.#: _____

Medical record #: _____

I authorize VIP physicians, nurses, and other personnel to share the following health information with the family members or other individuals listed below to assist in the coordination of my child's care or payment for my child's care:

TYPE OF INFORMATION : Please indicate the type of information to be released.
A = All M= Medical B= Billing or Financial S = Appointments or other scheduling.

NAME	RELATIONSHIP TO PATIENT	Type Code

Describe any legal proceedings that might impact any individual's right to access the patient's information.

_____

_____

Specific Instructions or Limitations:

_____

_____

Validation Code: _____ Please provide this code to any individual authorized to receive health information about my child. They will be asked for this code before information will be released over the phone. I understand that my refusal to sign this authorization will not affect my child's ability to obtain treatment. I understand that I may revoke this authorization in writing at any time by notifying the Medical Information Services Office (address provided below), but if I do, it will not have any effect on actions VIP Midsouth, LLC has taken in reliance on this authorization prior to receiving the revocation. This authorization will expire when the minor patient reaches the age of 18. I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information.

Signature of Parent/
Legal Guardian: _____ **Date:** _____

Relationship to Patient: _____

To revoke this authorization, please send a written request with a copy of this form to the address below:

VIP Midsouth
648 Hartsville Pike
Gallatin, Tennessee 37066
Attn: Medical Records