The Children's Clinic

GREENVILLE HEALTH SYSTEM

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Permission to give treatment to a minor accompanied by person(s) other than the legal guardian

The following family member(s), friend(s), or caregiver(s) have my permission to bring my child in for treatment and/or vaccines and have access to my child's Protected Health Information.

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

It is my responsibility to contact the practice with any addition or deletions from this list. This authorization will be effective until the legal guardian cancels or requests changes to be made. If the person(s) authorized above or the legal guardian calls for access to the minor's PHI or billing information, they will have to give the following identifiers in order to have access to the information over the phone.

a. Minor Patient's Name ______________________________

b. Minor Patient's DOB ______________________________

c. Minor Patient's Mother's Maiden Name ______________________________

d. Requestor's Relationship to patient as stated above.

Minor Patient's Name: ______________________________

Signature of Legal Guardian: ______________________________

Date: ____________________

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