Lurie Children's Primary Care

Minor Accompanied by Non-Guardian

5519

Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

MINORS ACCOMPANIED BY SOMEONE OTHER THAN LEGAL GUARDIAN

The purpose of this form is to identify individuals you would allow to bring your child for visits to Lurie Children's Primary Care, LLC and also to authorize the disclosure of information during visits. This form will be valid one year from the date of signature unless otherwise revoked.

Name of Child: _____ Child's Date of Birth: _____

Today's (Effective) Date:_____

I authorize the following individual(s) to transport my child (listed below) to and from his/her medical appointments:

Name: _____ Relationship: _____
Please Print Name

Name: _____ Relationship: _____
Please Print Name

Name: _____ Relationship: _____
Please Print Name

Name: _____ Relationship: _____
Please Print Name

The above named individual(s) are authorized to accompany my child to and from his/her appointments. I acknowledge that I remain the child's legal guardian and that I, and/or the child's other legal guardian (if applicable), must be available by telephone call during the appointment at the number(s) listed below to discuss or consent to any further medical treatment.

I hereby authorize the protected health information regarding the above-named person to be exchanged between Lurie Children's Primary Care and the individuals listed above for the following purpose: Allowing the above-named individuals to accompany my child for his/her appointment and to receive information directly relevant to such individuals' presence at my child's appointment. I understand that sensitive information may be shared including Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Disease, Pregnancy and Birth Control.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Lurie Children's Primary Care may refuse to treat me if I do not sign this Authorization.

I understand that once Lurie Children's Primary Care discloses my health information to the recipient, Lurie Children's Primary Care cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Lurie Children's Primary Care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that Lurie Children's Primary Care may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.

I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Lurie Children's Primary Care to use or disclose my health information in the manner described above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____ DATE: _____ TIME: _____

PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

INTERPRETER (as applicable): _____ DATE: _____ TIME: _____