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**MINOR’S AUTHORIZATION TO SHARE MEDICAL INFORMATION WITH PARENT/GUARDIAN AGE 12-17 yrs**

***PLEASE READ ALL INFORMATION AND INSTRUCTIONS BEFORE COMPLETING AND SIGNING THIS FORM***

**PATIENT NAME:** **DOB:** / /

**MINORS AGE 12-17:** A minor patient’s signature is required in order to release the following information: (1) conditions relating to the minor’s reproductive care including, but not limited to: contraception, pregnancy and pregnancy termination, sterilization and sexually transmitted diseases (age 12 and older), (2) alcohol and/or drug abuse (age 12 and older), and mental health conditions (age 12 and older).

**I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named below. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the person(s) named below. I am aware I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).**

***(Printed below are the name(s) and relationship of those who may receive above said information)***

Name: Relationship:

Name: Relationship:

 I do not grant any permission for my above mentioned medical health information to be released to anyone other than myself.

 **This authorization expires on (Date or Event). Authorization will expire in one year if not otherwise specified.**

**Patient Signature: Date:**

**Printed Name:**

**Parent or Legal Guardian Signature: Date:**

**Printed Name: Relationship to Patient:**

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