EAGAN VALLEY PEDIATRICS

AUTHORIZATION FOR FAMILY MEMBER ACCESS TO PRIVATE HEALTH INFORMATION

Patient Name_____ Birth Date_____

Patient Phone #_____

I, _____, authorize Eagan Valley Pediatrics to disclose my Protected Health Information including billing information to the following family members:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I may revoke this authorization by sending a written request to Eagan Valley Pediatrics. I also understand when Eagan Valley Pediatrics discloses this information pursuant to this authorization; the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. This is effective for 1 (one) year unless otherwise specified.

I understand and agree to the terms of this authorization.

_____ _____

Patient Signature Date

Is your address different than your parents address? Yes No
If yes, please provide your address

_____

_____

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Updated 04-19