THH PEDIATRICS
TENDER HEARTS & HANDS

MAPP
MID ATLANTIC PEDIATRIC PARTNERS

Metropolitan Pediatrics

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AUTHORIZATION FOR NON-PARENTAL ADULT

For a designated adult accompanying a minor patient

You may elect to provide Mid Atlantic Pediatric Partners (MAPP) written authorization to disclose your minor child's protected health information to anyone you designate, such as a family member or personal representative. That designee may also have your permission to bring your minor child for office visits in your absence. If you choose to authorize a legal adult to bring your child/children to see one of our providers and make all medical decisions in your absence, please complete this form.

PATIENT INFORMATION

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

AUTHORIZED NON-PARENTAL ADULT(S)

I request and authorize Mid Atlantic Pediatric Partners (MAPP) to permit my child/children to be seen by a provider with the following legal adult present:

Legal adult name: _____ Relationship to patient: _____

Legal adult name: _____ Relationship to patient: _____

Legal adult name: _____ Relationship to patient: _____

Legal adult name: _____ Relationship to patient: _____

TERMS AND SIGNATURE

I understand that I have the right to revoke this authorization at any time by giving Mid Atlantic Pediatric Partners (MAPP) written notice prior to any services. I understand that a revocation is not effective in cases where the legal adult has previously been present for a visit, but will be effective going forward. I also understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the parent or patient.

Signature: _____ Date: _____

Phone number: _____ Relationship to patient: _____

REVOCATION

Date authorization revoked: _____ Parent/guardian/patient signature: _____