Pediatric Dermatology
of North Texas

Minor Child Private HIPAA Information Consent

Patient Last Name	First Name	Date of Birth

I understand that medical and/or payment information about my minor child's condition and treatment may be released to treating physicians in consultation with Pediatric Dermatology, Pharmacists/Pharmacies and Insurance Providers. However, medical and payment information about a minor child may NOT be given to <u>any individuals</u> (mothers, fathers, step-parents, grandparents) unless permission is given below. PLEASE LIST PARENTS

Parent/Guardian Signature _____ Date _____

X_____

Name:_____ Relationship: MOTHER Phone number:_____	May have the following: Information about my appointments ( ) Information about by my treatment ( ) Information about my test result ( ) Information about my billing/payments ( )
Name:_____ Relationship: FATHER Phone number:_____	May have the following: Information about my appointments ( ) Information about by my treatment ( ) Information about my test result ( ) Information about my billing/payments ( )
Name:_____ Relationship:_____ Phone number:_____	May have the following: Information about my appointments ( ) Information about by my treatment ( ) Information about my test result ( ) Information about my billing/payments ( )
Name:_____ Relationship:_____ Phone number:_____	May have the following: Information about my appointments ( ) Information about by my treatment ( ) Information about my test result ( ) Information about my billing/payments ( )