Mississippi Children's HEART CLINIC

# AUTHORIZED PERSONS / HIPAA DISCLOSURE FORM

My signature below authorizes the following persons to bring my child in for treatment at Mississippi Children's Heart Clinic without my presence and to be given access to my child's Protected Health Information in accordance with HIPAA regulations.

| PERSON'S NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |
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I give permission to the physicians at Mississippi Children's Heart Clinic and their staff to disclose to the persons listed above my child's Protected Health Information including but not limited to treatment, testing and diagnosis (including picking up prescriptions and completed medical forms). I understand that those listed above may make decisions regarding the recommended treatment and testing by the physician and must be responsible for relaying details of the services rendered during my child's visit back to me. I further understand that I may revoke this authorization at any time with written notice to Mississippi Children's Heart Clinic.

Parent / Legal Guardian Signature: _____ Date: _____ / _____ / _____

Parent / Legal Guardian Name (Print): _____

Patient Name: _____ Date of Birth: _____ / _____ / _____