Patient Authorization for Use and Disclosure
of Protected Health Information to parents or legal guardians

By signing this authorization, I authorize Advocare _________________________(name of Care Center) to use and/or share certain protected health information (PHI) about me with:

Name **Relationship**

____

____

____

This authorization permits Advocare _______________________________to use and/or share with the individuals noted above any part of my individual identifiable health information, with the exception of information related to:

☐ **Alcohol & drug use** ☐ **Sexual activity or sexually transmitted disease** ☐ **Pregnancy** ☐ **Other**

This information will be used to help me make appropriate medical care decisions with the assistance of my parent(s) or legal guardian(s).

This authorization will expire on ____

Expiration date (22nd birthday or other date)

I do not have to sign this authorization in order to receive treatment from Advocare _________________. Additionally, I have the right to refuse to sign this authorization. When my information is used or shared based on this authorization, the recipient may share it with others and my PHI may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the Care Center has acted upon this authorization. My written revocation must be submitted to the Privacy Officer at:

____
Address

____
City State Zip Code

Signed by____
Signature of Patient

____ _____________
Patient Printed Name Date