Howard County Health Department
Authorization of Use and Disclosure of Protected Health Information of a Minor(s)

Client's Name:_____Date of Birth:_____Today's date_____

Siblings' Names that same information applies:
Name: _____ Birth Date: _____

Name: _____ Birth Date: _____

Name: _____ Birth Date: _____

Name: _____ Birth Date: _____

To the patient: The Howard County Health Department (HCHD) will attempt to follow your instructions to the extent the healthcare provider believes such disclosure will not interfere with your treatment. Please, note that the HCHD does not need specific authorization to disclose information for treatment, operations or payment purposes consistent with its Notice of Privacy Practices.
Regarding vaccines: names of persons authorized to bring minor children for vaccinations will be posted in CHIRP (ISHD data base).

Authorization By: ____Patient ____ Legal Guardian: _____

I,_____, authorize the following person(s)

- ☐ to have access to Health Information covered under the Privacy Practice
- ☐ to make vaccination decisions in my absence in regard to my minor child

_____ _____
(Please Print Name) (Relationship)

_____ _____
(Please Print Name) (Relationship)

_____ _____
(Please Print Name) (Relationship)

Limitations: This Authorization applies only to Vaccinations unless indicated below. Please, list any other health information that you do not want the persons listed on the previous page to have access i.e. Lead testing information or TB tests.
*The following Protected Health Information may disclosed:*_____ Initials_____

Expiration: I understand this Authorization will stay in effect at the HCHD unless it is revoked/revised by me **in writing.** I understand that HCHD is not responsible for information that might be re-disclosed by those persons who I have authorized to receive information.
Initials_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement
I,_____, have received a copy of this office's Notice of Privacy Practices.
Print Name
Patient/Guardian Signature:_____ **Date:**_____

Witness:_____Date:_____

Methods of Communication

In addition to a phone call, would you like other forms of an **Appointment Reminder?**

- TEXT Message on my CELL PHONE ____YES ____NO #_____
- EMAIL Message ____YES ____NO _____

----------**For Office Use Only** ----------
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____Individual refused to sign _____Communications barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement _____Other (Please, specify)