H E R R I N P E D I A T R I C C L I N I C
JAMES R HERRIN, M.D., F.A.A.P.
601 River Pointe Dr. Suite 120
Conroe, Texas 77304

GUARDIAN / MINOR CHILD AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE[S]

I, _____ the named legal guardian[s] of

_____[minor child] give permission to release protected health information including results of laboratory tests, x-ray and / or other test results to the following designated representative[s]:

Guardian's Initials

_____ My spouse [Name]_____

_____ My relative [Name]_____[relationship]

_____ Other [Name]_____[relationship]

_____ May be left on my answering machine at home / voice mail on cell phone

_____ May be left on voice mail at work

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF

_____ _____
Guardian's Signature Date

_____ _____
Witness Date

As the legal guardian, you have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, HERRIN PEDIATRIC CLINIC must receive the revocation in writing. The revocation must include: [1] the patient's name, address, and date of birth, [2] the guardian's desire to revoke the authorization, and [3] the date of the revocation and the guardian's signature. All revocations must be sent in writing to the attention of Privacy Officer at 601 River Pointe Dr, Suite 120 – Conroe, Tx 77304 or faxed to 936-788-6061. It will not be considered effective until received by the Privacy Officer.