MEDICAL RELEASE
SPECIAL AUTHORIZATION FORM FOR MINORS

I, _____, authorize the following name person/persons to authorize (Medical/Dental) treatment for my child/children by this facility.

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

I understand that I may terminate this authorization form. I must notify this facility in writing regarding termination and effective date.

NAME OF PERSONAL REPRESENTATIVE	RELATIONSHIP
_____	_____
_____	_____
_____	_____

NAME OF CHILDREN	AGES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signed by: _____

Relationship to Child: _____

Date: _____

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility to speak to the following family members or my personal representative regarding

□ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

□ Only the following types of information:

_____

_____

_____

The above medical information shall only be released to the following persons:

Family Member / Personal Representative	Relationship
_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)
□ Until revoked in writing.
□ Until _____, 20____

I know that I am entitled to receive a copy of this agreement.

Name _____

Signature _____

Signed this _____ day of _____, 20_____