# Pediatric Associates of Barrington, S.C.

**www.pediatric-associates.net**

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**RE: DISCLOSURE FOR HEALTH CARE OR PAYMENT FOR HEALTH CARE**

(Request for persons **OTHER** then Parent/Guardian/Personal Representative to participate in health care, i.e. sitters, grandparents, friends, etc.)

**DATE: ____________________**

I give my permission for ____________________________________________to authorize and sign
Name and relationship of authorized individual(s) other than parent /guardian/ personal rep
for vaccines and medical treatment for____________________________________________, my minor
Patient Name(s) and Date(s) of Birth
Child(ren). As parent or guardian and personal representative (as that term is defined by HIPAA) for my child, I also authorize Pediatric Associates of Barrington, S. C. to disclose protected health information to ____________________________________________regarding my child's
Name and relationship of authorized individual(s) other than parent / guardian/ personal rep.
health care or payment for health care.

______________________________________________
Parent or Guardian (Personal Representative) Signature

Print Name : ___________________________________


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