Patient Label

OSF HealthCare

MINORS ACCOMPANIED BY NON-PARENT/NON-LEGAL GUARDIAN
(Authorization for a non-parent/non-legal guardian to participate in a minor's care)

This form allows the designated individual to:

- Accompany the named minor to scheduled appointments;
- Participate in such scheduled appointments with the named minor;
- Receive protected health information of the named minor relating to/in the course of the care provided at the appointment(s) at which the individual is present; and
- To make routine follow-up appointments for the named minor.

What this form does not do:

- Does not establish short-term guardianship of the named minor
- Does not allow the individual to make medical decisions on behalf of the minor. The legal guardian listed in the patient's record will be contacted to make medical decisions.

I, _____, parent/legal guardian of (include name and birthdate of the minor patient) _____, hereby give permission to (name(s)) _____ _____ residing at (address) _____ to accompany the minor patient noted above and to participate in scheduled appointments with **(**name of provider**)** _____.

☐ I hereby authorize the above-named individual to participate in scheduled appointments with a substitute provider in those instances when the above-named provider is temporarily unavailable.

I acknowledge that this form shall begin on (date) _____ and shall end on (end date) _____, **or if an end date is not otherwise specified, shall remain in effect for a period of one (1) year.**

In the event medical decision-making is required and/or consent to further medical treatment is needed, I can be reached at the following phone number: _____

I hereby authorize the protected health information regarding the above-named person to be exchanged between OSF Healthcare System/OSF Multi-Specialty Group (collectively, "OSF") and the individual listed above for the following purpose: Allowing the above-named individual to accompany the named minor for the minor's appointment(s) and to receive information directly relevant to such individual's presence at the above-named minor's appointment(s). I understand that sensitive information concerning the named minor may be shared, including Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Disease, and Reproductive Health information.

THE NEXT PAGE OF THIS FORM MUST BE COMPLETED

I understand that this authorization is voluntary and I can refuse to sign this authorization. I understand that person(s) or organization(s) may NOT condition the minor patient's treatment, payment, or enrollment based on my signature on this authorization. However, if treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this form, OSF may refuse to treat the patient if I do not sign this form.

I understand that under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act and/or the Confidentiality of Substance Use Disorder Patient Records regulations, certain health information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes re-disclosure.

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and once the information is re-disclosed it may not be protected by HIPAA or other applicable privacy laws. I understand that I have the right to revoke my authorization under this form at any time. I understand that if I revoke my authorization, I must do so in writing and present my written revocation to OSF. I understand that the revocation will not apply to information that has already been released in response to this form.

I understand that as the parent or legal guardian of the minor patient identified herein, that I have the right to inspect and obtain a copy of the minor's medical records, subject to applicable law.

I have read and understand the terms of this form and I have had the opportunity to ask questions about the use and disclosure of the named minor patient's health information. By my signature, I hereby knowingly and voluntarily authorize OSF to use or disclose the minor patient's health information in the manner described above.

Date/Time: _____

Signature (Parent/Legal Guardian): _____

Printed Name (Parent/Legal Guardian): _____

Printed Name of Minor Patient: _____

Relationship to the Minor: _____

Witness (Office Personnel and/or Notary): _____