north valley
ear, nose & throat
associates, PC

**Peter C. Kaiser, MD**
**Michael T. Gutman, MD**
**Joseph A. Chiara, MD**
board certified
otolaryngology, head and neck surgery

# Authorization to Treat a Minor and Disclose PHI

PATIENT NAME: _____ DATE OF BIRTH OF PATIENT: _____

This authorization gives NVENT permission to disclose the elements of my child's protected health information to the person(s) listed below. The person(s) listed below also has permission to bring the patient to his/her appointments and make medical decisions for the patient on my behalf while the patient is in the office. I understand that any authorization for surgery will require parental/guardian written consent:

1. Name: _____ Relationship to Patient: _____

Phone: _____ Address: _____

2. Name: _____ Relationship to Patient: _____

Phone: _____ Address: _____

3. Name: _____ Relationship to Patient: _____

Phone: _____ Address: _____

4. Name: _____ Relationship to Patient: _____

Phone: _____ Address: _____

5. Name: _____ Relationship to Patient: _____

Phone: _____ Address: _____

This authorization will remain valid for 10 years after signing or the patient's 18th birthday (if a minor).

I understand that I may revoke this authorization in writing at any time, but that this revocation will not affect any prior authorized disclosures that have been taken by **North Valley E.N.T. Associates, P.C**.

_____ _____ _____
Parent/Guardian Signature Date Printed Name & Relationship to Patient

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