

**AUTHORIZATION FOR RELEASE OF MINOR AND/OR MINOR'S RECORDS
TO PERSON OTHER THAN PARENT OR GUARDIAN**

Name and Address of Facility Where Minor and/or Minor's Records are Located:

I/We, as the parent(s) or guardian(s) of _____, born _____
(Name of Minor) (Date)

at _____ hereby: (Mark out any statement that does not apply)
(Place of Birth)

- 1. Authorize the Service Unit Director of the above facility, or his/her designee, to release, when ready for discharge, said minor into the care of:

(Name of Individual or Agency)

(Address)

- 2. Authorize the Service Unit Director of the above facility, or his/her designee, to furnish information from or copies of said minor's health record, covering the following dates (inclusive) _____ to _____, to:

(Name of Health Professional or Agency)

(Address)

I/We have read the above (the above has been read and explained to me/us by: _____) and this consent is voluntarily executed. (Name)

PARENT(S) OR GUARDIAN(S):

(Signature) (Date) (Address)

(City) (State)

(Signature) (Date) (Address)

(City) (State)

WITNESS:

(Signature) (Date) (Address)

(City) (State)

PATIENT'S IDENTIFICATION	NAME (First, M.I., Last)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH