University Hospitals

Sandusky Pediatricians, 2800 Hayes Avenue, Bldg. B, Sandusky OH 44870, (419) 626-3821

Date: _____

Patient Name: _____ Date of birth _____

Patient Name:_____ Date of birth _____

Patient Name:_____ Date of birth _____

Patient Name:_____ Date of birth _____

Patient Name:_____ Date of birth _____

PLEASE COMPLETE THIS FOR ANY PERSON WHO IS NOT A PARENT OR LEGAL GUARDIAN, SUCH AS A STEPPARENT OR GRANDPARENT, THAT YOU WISH TO ALLOW PARTICIPATION IN YOUR CHILD'S CARE.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), I _____ authorize my provider, ***SANDUSKY PEDIATRICIANS**, to discuss my health information with the following individuals. I understand that, before certain health information (such as HIV status, substance abuse treatment, and mental health treatment) may be discussed, I might be required to complete an Authorization to Release Medical Information.

1) _____ Relationship: _____

Phone Number: _____

2) _____ Relationship: _____

Phone Number: _____

3) _____ Relationship: _____

Phone Number: _____

4) _____ Relationship: _____

Phone Number: _____

5) _____ Relationship: _____

Phone Number: _____

_____

Patient signature or legal representative

***Stephen J. Dutko, MD / Kimberly A. Vacca, MD / Terry E. Wiseman, MD / Ashley M. Folger, NP-C**