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HIPAA Authorization for Use or Disclosure of Health Information for a Minor

This form is for use when such authorization is required for a minor (under 18) and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

If the patient is a minor or unable to sign, please complete the following.

Print Name of Patient: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient is a minor: \_\_\_\_\_ years of age.

Patient is unable to sign because: \_\_\_\_\_

\_\_\_\_\_

Signature of Authorized Representative

Date

Printed Name of Authorized Representative

Authority of representative to sign on behalf of the patient listed above:

Parent     Legal Guardian     Court Order     Other \_\_\_\_\_