Southlake Pediatrics, Inc.
5000 Southlake Park, Suite 250
Birmingham, AL 35244
(205) 982-2500
(205) 982-2574

Alternative People
Communication Authorization Form
(Patient's 14 years of age or older)

Patient name: _____ **D.O.B.**_____

In accordance with the Health Insurance Portability and Accountability Act (HIPAA); the following applies regarding ***consent of minors***:

1. Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced, or is pregnant, may give effective consent to any legally authorized medical, dental, health, or mental health services for himself or herself (Code of Alabama, Section 22-8-4).
2. Any age of minor may give effective consent for any legally authorized medical, health, or mental health services to determine the presence of, or to treat, pregnancy, venereal disease, drug dependency, alcohol toxicity, or any reportable disease (Code of Alabama, Section 22-8-6).
3. Any legally authorized medical, dental, health, or mental health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life, health, or mental health (Code of Alabama, Section 22-8-3).

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care as a patient and you will want our office to be able to communicate directly with them. In order to protect your privacy of personal health information, please share with us the names of any other people with whom we can discuss your medical care and share your protected health information.

Please list below any other people, with whom you authorize our office to discuss aspects related to your medical care.

Name: _____ **Relation to patient:** _____ **Ph#**_____

Name: _____ **Relation to patient:** _____ **Ph#**_____

Name: _____ **Relation to patient:** _____ **Ph#**_____

Name: _____ **Relation to patient:** _____ **Ph#**_____

Are we authorized to communicate your medical treatment with your emergency contact located on the patient demographic sheet? Yes_____ No_____

Patient Signature: _____ Date: _____