

**Authorization for Release of Medical Information Under HIPAA and
Permission and Consent for Treatment
(pertinent for children 0-18 years of age)**

Child's Name _____ Phone _____ Birth Date _____
Address _____ Lives with _____

Parent(s) or Guardian(s) _____ Phone(if different) _____
Phone (work and cell): _____

Emergency Contact _____ Relationship to child _____
Phone (home, work and cell): _____

Alternate Contact _____ Relationship to child _____
Phone (home, work and cell): _____

My child attends _____ school.

Allergies, if known: _____ Approx. wt. and ht. _____

Major health concerns: _____ Medications: _____
(Use back of form or additional paper if necessary.)

Doctor: _____ Address: _____ Phone: _____

Other health issues concerning your child: _____

Health Insurance Policy (name and account number): _____

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In the event of my absence, I, _____ (parent/guardian), authorize, give permission, and consent to any one of the following employees or agents of Grace United Methodist Church, Decatur, Illinois, to make decisions and sign consent authorizations in regard to emergency medical treatment or care for (child's name) _____ deemed necessary by health professionals: Directing Pastor (now, Rev. Danny Cox); Associate Pastor (now, Rev. Sara Isbell); Director of Youth and Family Ministries (now, Chris Schubert); or, Parish Nurse (now, Joan Lester RN, BSN).

I further authorize release of all health information to the above-named employees or agents from any health professionals that may possess medical information about my child, if and when that information may be pertinent to the emergency treatment decisions.

The Authorization, Permission and Consent contained herein may be revoked at any time by delivering a written notice of revocation to the church. They automatically expire one year from this date. I have the right to change information at any time.

Furthermore, I agree to hold harmless Grace United Methodist Church, Decatur, Illinois, its employees, agents and members from any claims that I or the child may have in connection with any church activity, or with the treatment or the decision to seek treatment, or the authorization for treatment in my absence.

Signature Parent/Guardian _____ Date _____

Witness _____ Date _____