AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO A THIRD PARTY

This authorization gives any and all Health Care Providers permission to disclose health information about your child/minor to the named representative of New Goshenhoppen United Church of Christ for the indicated period of time.

This authorization may be revoked at any time by submitting a written revocation to New Goshenhoppen United Church of Christ.

1). I,_____ (Parent of Guardian) hereby authorize any and all Health Care Providers to disclose the specific health information described below, only for the purposes, the duration of time, and to the parties described below.

2). Description of the specific information to be disclosed: room/location of patient, Laboratory results, billing information, diagnosis, and treatment.

3). Duration of time that the authorization to disclose exists

from _____ until _____

4). Identity of the recipients of the information: Christian Education Director, Jeanine Roth, or her designee:

Senior Pastor_____,

Associate Pastor_____,

Youth Leader _____.

_____

Name of minor/patient (please print)

_____ _____

Signature of parent/guardian Date

If I, _____ (Parent of Guardian), choose NOT to sign this authorization granting permission for the Christian Education Director or their designee to act in my place, I will personally pick up and be responsible for the medical treatment of my child as it may become required.

_____ _____

Signature of parent/guardian Date

In the event of an emergency, every effort will be made to contact the parent or guardian. I understand that if I cannot be contacted, the Church staff will obtain emergency care and I will be responsible for the payment of the expenses that are incurred.

_____ _____

Signature of parent/guardian Date