Daystar
counseling ministries, inc.

HIPAA Privacy Authorization For Minor Clients

Authorization for Use or Disclosure of Protected Health Information

1. I hereby authorize Daystar Counseling Ministries, Inc. to release the complete client record for my minor child, _____, to the following recipient at the physical mailing address and/or electronic mailing address noted below:

Recipient _____

Recipient's Mailing Address _____

Recipient's E-mail Address _____

1. This authorization shall be in force and effect for all periods past, present, and future until revoked in writing or otherwise required by applicable law. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that (a) any person or entity has already acted in reliance on my authorization or (b) if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

2. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

3. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

4. I represent and warrant to Daystar Counseling Ministries, Inc. that (a) I have the legal capacity and authority to sign and deliver this release; (b) there is no legal agreement prohibiting me from authorizing Daystar to release these records; and (c) no judge having jurisdiction over the custody of the minor child referenced above has prohibited me from obtaining these records or from directing Daystar to release these records.

Signature of Person Requesting Information _____

Printed Name of Person Requesting Information _____

Date _____

Relationship to the Minor Child _____

Requesting Person's Address _____