PERSONAL REPRESENTATIVE FOR MINOR

I, ______________________________, parent of ______________________.

Give ______________________________ (stepparent) the authority to sign for,

And to authorize treatment of the above-named minor.

This authorization will remain in effect indefinitely or until I, ________________,

Revoke it.

This is in accordance to the Lincoln County Health Department HIPAA Privacy Policy and Procedure #3.

______________________________________ ________________

Signature Date

______________________________________ ________________

Witness Date

114 West Court Street PO Box 187 Lincoln, Kansas 67455
Phone : 785-524-4406 Fax : 785-524-5003
E-mail : lchd@lincolncopublichealth.org website : www.lincolncoks.com