Metropolitan Pediatric Specialists, P.A. | An affiliate of Children's Hospitals and Clinics of Minnesota

I, _____DOB:_____ grant permission for
(Patient name)

Metropolitan Pediatric Specialists to discuss with _____
regarding my current health care status with the exception of those items that are protected by MN State Law, which include but are not limited to pregnancy, sexually transmitted diseases, contraception, alcohol or drug abuse and mental health.

I understand that this written notification is effective immediately and indefinitely and can only be revoked or changed by myself in writing. This is in accordance with HIPAA regulations.
_____ Date: _____

If not signed in office at time of visit, signature must be notarized.

Subscribed and sworn before me, this _____ day of _____, _____
in and for _____ County.
State of _____.

_____
Signature
NOTARY PUBLIC

My commission expires: _____, _____.