

LIBERTY MOUNTAIN PEDIATRICS
4600 Hwy 280 South, Suite 103
Birmingham, AL 35242
(205) 709-1650



Alternative People
Communication Authorization Form
(Patient's 14 years of age or older)

Patient Name: _____ D.O.B. _____

In accordance with the Health Insurance Portability and Accountability Act (HIPAA); the following applies regarding consent of minors:

1. Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorces, or is pregnant, may give effective consent to any legally authorized medical, dental, health, or mental health services for himself or herself (Code of Alabama, Section 22-8-4)
2. Any age of minor may give effective consent for any legally authorized medical, health, or mental health services to determine the presence of, or to treat, pregnancy, venereal disease, drug dependency, alcohol toxicity, or any reportable disease (Code of Alabama, Section 22-8-6)
3. Any legally authorized medical, dental, health, or mental health services may be rendered to minors of age without the consent of a parent or legal guardian when, in the physicals judgement, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life, health, or mental health (Code of Alabama, Section 22-8-3)

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care as a patient and you will want our office to be able to communicate directly with them. In order to protect your privacy of personal health information, please share with us the names of any other people with whom we can discuss your medical care and share your protected health information.

Name: _____ Relation to patient: _____ Ph# _____
Name: _____ Relation to patient: _____ Ph# _____
Name: _____ Relation to patient: _____ Ph# _____

Are we authorized to communicate your child(ren)'s medical treatment with your emergency contact located on the patient demographic sheet? Yes _____ No _____

Parent/Guardian Signature: _____ Date: _____