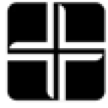

UnityPoint Health
Trinity

Parental Rights Verification Form

For your protection, and the person of whom you are requesting copies, we need verification from you that you are entitled to receive the requested copies of your minor child's medical records.
By signing below I am verifying that there is not a court or restraining order that limits my access to this patient's health information.

I am entitled to receive the medical records of my

Child:____________________________________
Print Child's Name

I,____, agree that
Print Parent's Name

my parental rights have not been terminated.

____
Parent's Signature

____
Date

Rev.11/2014