Date:_____

Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Mother's Name: _____ Father's Name: _____

Married: _____ Separated: _____ Divorced: _____ Other: please specify_____

Please remember to protect the privacy of your child we must have your written consent to evaluate and treat your child during each visit. Please list the following information for each of the individuals you are authorizing to accompany your child to visits including but not limited to sick visits, well child checkups, nurse visits, etc. This authorization also gives us consent to release any information regarding your child's health and/or treatment to the below individuals including appointment times and diagnosis. In addition, we ask that you provide copies of any applicable legal custody paper, orders, medical authorizations, etc. to our office. Please note that we cannot prevent a biological parent or legal guardian from receiving information or accompanying his/her child to a visit without legal documentation.

**This form overrides all authorization or consents submitted previously.
**This authorization expires 1yr from date signed.

1-Name: Relationship to the child: DOB:
_____ _____ _____
Address: Phone Number:
_____ _____

2-Name: Relationship: DOB:
_____ _____ _____
Address: Phone Number:
_____ _____

3-Name: Relationship: DOB:
_____ _____ _____
Address: Phone Number:
_____ _____

*Please note photo identification will be requested.

I understand that my child(ren)'s records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that this authorization may be revoked in writing at any time, and that the disclosed information may be subject to disclosure by the recipient although discouraged.

Prohibition on Re-disclosure: This information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (42CPRPart2) prohibit recipients from making any further disclosure of the information except with the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for that purpose.

Those listed above have my permission to accompany my child to PediDocs PLLC. In addition, the above named individuals have my permission to receive all pertinent health information regarding my child from PediDocs PLLC. This authorization shall remain valid until written notice to the contrary is received.

_____ _____ _____

Signature Relationship to child Date