PRIMARY PEDIATRICS

NAME OF PATIENT: _____ **DATE OF BIRTH:** _____

☐ I GIVE CONSENT FOR THE FOLLOWING PEOPLE TO RECEIVE MEDICAL INFORMATION ON MY BEHALF. THIS INCLUDES DIAGNOSIS, TEST RESULTS, LABORATORY RESULTS AND PRESCRIPTION INFORMATION. THIS CONSENT WILL REMAIN IN EFFECT UNTIL I REVOKE THE CONSENT IN WRITING.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

SIGNATUREOF PATIENT 18 OR OLDER: _____

DATE: _____

OR

☐ I DO NOT WANT MEDICAL INFORMATION TO BE COMMUNICATED TO ANYONE BUT MYSELF. MY CONTACT NUMBER IS: _____

SIGNATURE OF PATIENT 18 OR OLDER: _____

DATE: _____

I REVOKE CONSENT FOR INFORMATION TO BE GIVEN TO THE ABOVE NAMED.

SIGNATURE OF PATIENT REVOKING CONSENT: _____

DATE REVOKED: _____