RTC Pediatrics
We care for kids

ADULT CONSENT FOR 18 YEARS AND OLDER

Name: _____ Date: _____

Date of Birth: _____ Cell Phone Number: _____

Email: _____

Address: _____

Now that you are over the age of 18, we need your permission to share medical information with anyone other than you. Please sign the waiver below to let us know if we have your permission to share your information and with whom.

I give my permission to share my medical information with:

___ Mom (Name) _____

___ Dad (Name) _____

___ Other (Name) _____

You may share:

___ All lab results

___ All medical information

___ Only lab results, but not those related to sexually transmitted infections (STI) or pregnancy

___ DO NOT SHARE any information with anyone but me

___ I give my permission for my Mom or Dad to pick up any and all forms or prescriptions on my behalf

___ I DO NOT give my permission for my Mom or Dad to pick up any forms or prescriptions on my behalf

Signature: _____