CONSENT TO SHARE MEDICAL INFORMATION

SOUTHSIDE PEDIATRICS

Effective Date: September 23, 2013

I the undersigned, parent/guardian, consent to the access of my child's protected medical health information in the case of my inability to communicate directly with the office. The following family members and/or friends may have limited access to my child's protected health information. I understand that I may revoke or change this consent at any time. I understand that it is the responsibility of the parent or guardian to maintain this list of names. Any updates or changes require a new consent form be completed and signed and return to the office.

I understand that the biological mother and father are always permitted to have access to my child's protected health information unless the parental rights of either the father or mother have been legally terminated by law.

Patient Name: ___________________________________ Date of Birth: _________

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend O Biological Mother O Biological Father

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend O Biological Mother O Biological Father

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Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend O Biological Mother O Biological Father

____ Date ___________________
Please Sign and Date

This copy will be maintained in the patient's medical record for reference by the office staff.