CONSENT TO SHARE MEDICAL INFORMATION

SOUTHSIDE PEDIATRICS

Expires 1 year from Today's Date: ________________

I the undersigned, parent/guardian, consent to the access of my child's protected medical health (PHI) 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 PHI. 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 by the biological parent/ guardian* ***ONLY.*** The form must be 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**: ________

Siblings: ____________________________ ______________________________________

____________________________ ______________________________________

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend OTHER: ________________________

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend OTHER: ________________________

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Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend OTHER: __________________________

____ Date ___________________
Please Sign and Date

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