

## CONSENT TO SHARE MEDICAL INFORMATION

### SOUTHSIDE PEDIATRICS

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 by the biological parent/guardian ONLY.** 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 & DOB: \_\_\_\_\_

Patient Name & DOB: \_\_\_\_\_

Patient Name & DOB: \_\_\_\_\_

Patient Name & DOB: \_\_\_\_\_

Name \_\_\_\_\_

Relationship:

- Grandmother     Grandfather     Aunt     Uncle     Guardian  
 Stepfather     Stepmother     Babysitter     Daycare Provider  
 Family Friend    Other: \_\_\_\_\_

Name \_\_\_\_\_

Relationship:

- Grandmother     Grandfather     Aunt     Uncle     Guardian  
 Stepfather     Stepmother     Babysitter     Daycare Provider  
 Family Friend    Other: \_\_\_\_\_

Name \_\_\_\_\_

Relationship:

- Grandmother     Grandfather     Aunt     Uncle     Guardian  
 Stepfather     Stepmother     Babysitter     Daycare Provider  
 Family Friend    Other: \_\_\_\_\_

Name \_\_\_\_\_

Relationship:

- Grandmother     Grandfather     Aunt     Uncle     Guardian  
 Stepfather     Stepmother     Babysitter     Daycare Provider  
 Family Friend    Other: \_\_\_\_\_

Name \_\_\_\_\_

Relationship:

- Grandmother     Grandfather     Aunt     Uncle     Guardian  
 Stepfather     Stepmother     Babysitter     Daycare Provider  
 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.**

*For the privacy and security of our patients, this form will be routinely updated at the request of the parent/guardian or as needed by the providers and staff of Southside Pediatrics.*