Pediatric Associates

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Permission to Communicate and Consent.

We need your written authorization to communicate with family members or others involved in your care (or your child's care). Note that once such person/s are provided with information, the information is no longer within the control of Pediatric Associates, LLC and it is possible that they will disclose it to others.

I, _____ authorize Pediatric Associates, LLC to release or discuss:

My minor child/children's health information:

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

First Person:

Name of person allowed: _____ Phone: _____

Relationship: Please circle one

Spouse/Partner	Mother/Father/Stepparent	Foster Parent
Grandparent	Niece/Nephew	Son/Daughter
Social or DCF worker	Aunt/Uncle	Health care Representative

Other: _____

Please select only ONE option and Initial

_____ NO RESTRICTIONS: I give the above-named individual permission to act on my behalf with no limitations. I understand they may contact any physician or member of the staff at Pediatric Associates, LLC to schedule appointments, discuss healthcare, access medical records and has consent to treat.

____ I give the above-named individual permission to contact and speak with any physician or member of the staff at Pediatric Associates, LLC to discuss care and schedule any needed services or appointments. I DO NOT GRANT CONSENT TO TREAT

___ I give the above-named individual permission to contact and speak with any physician or staff member of Pediatric Associates, LLC for the sole purpose of scheduling an appointment. No access to medical records or information regarding care can be discussed or provided. APPOINTMENT ACCESS ONLY

Second Person:

Name of person allowed: _____ Phone: _____

Relationship: Please circle one

Spouse/Partner	Mother/Father/Stepparent	Foster Parent
Grandparent	Niece/Nephew	Son/Daughter
Social or DCF worker	Aunt/Uncle	Health care Representative

Other: _____

Please select only ONE option and Initial

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I will be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that Pediatric Associates LLC may not condition treatment, payment or enrollment/ eligibility for benefits on my decision to sign this form. I understand that I may revoke this permission by notifying Pediatric Associates LLC in writing of my revocation. This permission is effective until revoked.

Signature: _____ Date: _____