Consent For Communication For Involvement of Care

I, the undersigned, do hereby consent and request that Columbus Pediatrics and Adolescent Care communicate with or release health information concerning my child, if communication is in my child's best interest and is only information that is directly relevant to designated individual's involvement with my child's health care, treatment decisions, patient education and medical bills.

Please note: This does NOT allow our nursing staff to discuss specific lab results of imaging reports with the designated individual, nor does it all the designated individual to access the medical record.

Patient's name: _____ DOB: _____

The following are the names of individuals whom I want to have health information as outlined above:

1. Name: _____ Phone: _____

   Relationship to patient: _____

2. Name: _____ Phone: _____

   Relationship to patient: _____

3. Name: _____ Phone: _____

   Relationship to patient: _____

_____ _____ _____

Date Signature of Authorized Party Printed Name

I do NOT grant consent for anyone to be given information regarding my child's heatlh care or treatment except as required by law.

_____ _____ _____

Date Signature of Authorized Party Printed Name