CAROLINA PEDIATRICS OF THE TRIAD

Permission to Discuss PHI

Patient Name: _____ Date of Birth: _____

Account Number: _____

I hereby give permission to the person(s) listed below to consent to evaluation, treatment, lab work, and vaccinations for the above named patient. This person(s) may also receive information about the care of the above named patient. This list **must** include the name of each parent and any legal guardian(s).

NAME	RELATIONSHIP

_____
Print Name of Patient, Parent, or Legal Guardian

_____
Signature

_____
Relationship to Patient

_____
Date