

**Pediatric Consultants  
Release Form for individuals involved in care of patient**

I, \_\_\_\_\_, give Pediatric Consultants, P.C. permission to speak with the following people regarding my child's health status, including diagnosis, treatment options and plans and payment for health services I receive from Pediatrics Consultants, P.C.

This consent is valid until such time as I provide a written revocation to Pediatrics Consultants, P.C.

**Patient Name:** \_\_\_\_\_  
**Patient's DOB:** \_\_\_\_\_

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**Patient's DOB:** \_\_\_\_\_

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**Patient's DOB:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
**Patient's DOB:** \_\_\_\_\_

Pediatrics Consultants, P.C. may speak with:

Name \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

This form is to be filed in the patient's medical record  
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