CONSENT TO SHARE MEDICAL INFORMATION WITH PARENT OR GUARDIAN

_____ _____

Name Date of Birth

I give permission for Woodinville Pediatrics to discuss my medical care with my parent(s) or guardian(s):

_____ and/or _____

Name Name

Including medical and surgical treatment, x-ray, examinations, laboratory procedures and test results.

I also understand that if a medical insurance claim is submitted, confidentiality may not be guaranteed.

_____ _____

Date Signature of Patient