CONSENT TO SHARE MEDICAL INFORMATION WITH PARENT OR GUARDIAN

Patient's Name	Date of Birth	Patient's Cell Phone
_____	_____	_____

I give / do not give permission (**circle one**) for Woodinville Pediatrics to discuss my medical care with my parent(s) or guardian(s):

_____ and/or _____

Parent/Guardian Name — Parent/Guardian 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
_____	_____