ATLANTA
PEDIATRIC PARTNERS

# Patient Permission Form

I have agreed to allow certain individuals to participate in the discussion and decisions to my child/children's medical care. As well to grant permission for the individuals to be able to act on my behave in case I'm not present at doctor's appointments. Therefore, I hereby give my permission for Atlanta Pediatric Partners, PC to disclose my personal medical information to the following individuals:

Name _____

Relationship to Parent _____

Name _____

Relationship to Parent _____

Conditions for Disclosure (Check item(s) that apply):

- ☐ The practice may disclose my personal health information to the individual(s) above in
- ☐ The practice may disclose my personal health information to the individual(s) above in discussions during my presence and when I am not physically present, including disclosures by telephone, fax, email or regular mail.
- ☐ Other conditions of disclosure:

  _____

I understand that his consent may be revoked at any time by written notice to the practice.

Patient's Name: _____

Date of Birth: _____

Parent's Name: _____

Parent's Signature: _____

Date: _____