Penfield Pediatrics, LLC

21 Willow Pond Way #200

Penfield, NY 14526

P:585-377-0840 F:585-377-9715

CONSENT TO SHARE MEDICAL INFORMATION WITH PARENTS/GUARDIAN

Name:

DOB:

I give Penfield Pediatrics, LLC my permission to share medical information with:

____

(Relationship to Patient) ____

____

(Relationship to Patient)____

I understand that I can revoke my permission at any time by written request.

Patient Signature: ____

Date:_____________________________