Owasso Pediatric and Adolescent Medicine

Guardian Consent Forms

I, _____, give Owasso Pediatric and Adolescent Medicine 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 Owasso Pediatric and Adolescent Medicine.

This consent is valid until such time as I provide Owasso Pediatric and Adolescent Medicine written revocation of it.

Patient Name:_____
Patient's DOB:_____

Owasso Pediatric and Adolescent Medicine may speak with:

Name _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient/Guardian Signature: _____

Date: _____

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