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Parental Permission To Speak

For Over 18 year old

Patient Name: _____

Patient Date of Birth: _____

I, _____ give permission for my mother/father/guardian,

(Patient Name)

_____ to discuss my healthcare and appointments with

(Name of mother/father/guardian)

any of the Providers or staff at Concord Pediatrics, PA.

_____ _____

Patient Signature Date

Patient's Cell Number: _____

This authorization is valid for one year from signature date.

Revised 7/13/2020