Donna Yeiser, MD

Kamie Theobald, FNP

CONSENT TO DISCUSS MEDICAL CARE

Date: _____

Patient Name (please print) ~~ Date of Birth

_____

_____

_____

_____

_____

_____

I authorize **Columbus Pediatric Associates** to discuss medical care on the above patient with the individuals listed below:

Name: _____ Relationship: _____ Phone #_____

Name: _____ Relationship: _____ Phone #_____

Name: _____ Relationship: _____ Phone #_____

Name: _____ Relationship: _____ Phone #_____

This authorization shall remain in effect unless revoked in writing by me.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____