Permission to Share Information
With Family and Friends

If you wish to grant permission for a friend or family member to accompany your child to appointments on your behalf or for us to share medical/billing information, please specify below. You may revoke this permission at any time by submitting a written statement.

I give my permission to Absolute Pediatric Therapy to share the health/billing information of (patient name)____, DOB____/____/____

with the following person or persons:

NAME	RELATIONSHIP	PHONE #
_____________________	______________________	___________________
_____________________	______________________	___________________
_____________________	______________________	___________________

Parent/Guardian Signature:____

Parent/Guardian Name (Print):____

Date:_________________