Aurora Pediatrics
Consent to Discuss Authorization

This form provides for situations where parents/legal guardians would like for individuals not otherwise included in usual HIPPA compliant communications to be able to discuss medical information about their child with Providers or Clinical Staff.

Patient Name:_____ DOB_____

Parent/Guardian Name_____ Phone_____
(if patient is <18 years old)
Address_____

I do hereby given my consent to the following individual(s)

Name_____ DOB_____
Relationship_____

Name_____ DOB_____
Relationship_____

Name_____ DOB_____
Relationship_____

Information that may be released:
Check all that apply
☐ Entire medical record
☐ Lab Reports/Results
☐ Chart Notes
☐ Radiology Reports/Results
☐ Pathology Reports/Results
☐ Emergency/Hospital Reports
☐ Other:_____

Date range:
☐ From _____ To_____
☐ All Dates of Service

Information protected by Federal Law must be specifically requested by initialing below
HIV/AIDS/STD and Reproductive Health related Test Results _____
Drug/Alcohol diagnosis and treatment_____
Mental Health information_____

I understand that I may cancel this authorization at any time by giving written notice to Aurora Pediatrics LLC. Unless canceled at an earlier date, this authorization will expire in 1 year from the date of signing or on _____.

Name_____ Relationship to Patient_____

Signature_____ Date_____
If patient is >18 years old, the signature must be that of the Patient or Legal Conservator and NOT the parent or guardian