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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 any of the  
(Name of parent/guardian)

Providers or staff at Concord Pediatrics, P.A.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Patient's Cell Number: \_\_\_\_\_

This authorization is valid for one year from signature date.