CONSENTS FOR MEDICAL CARE

Patient Name(s):_____

CONSENT TO THE EXCHANGE OF MEDICAL DATA

I state that I am the natural parent or legal guardian of the patient(s) listed above. In the interest of improving medical care and ensuring the safety of the patient(s) above, I voluntarily authorize and consent to the exchange of medical data, including but not limited to medications, consults, vaccinations, diagnostic tests and hospital records, between Western Loudoun Pediatrics and other healthcare entities.

AUTHORIZATION FOR ADDITIONAL CAREGIVERS, OTHER THAN PARENTS

I give permission to the following individuals to bring my children to the office and to authorize any medical treatment. I understand that I must notify Western Loudoun Pediatrics in writing with changes to any authorized caregivers.

Name	Relation	Phone
Name	Relation	Phone

EMERGENCY CONTACTS, OTHER THAN PARENTS

If urgent communication is necessary, please contact the person(s) listed below if you are unable to reach a parent

Name	Relation	Phone
Name	Relation	Phone

Signature _____

Print Name _____

Relationship to patient_____

Date _____