105 Collier Road Suite 4060 Atlanta, Georgia 30309 404 351 6662 f 404 351 6030 www.piedmontpediatrics.org

Patient Name: ______________________ D.O.B: ______________

Phone Number: _____________________ Email: ____________________________

PARENTAL AUTHORIZATION (for patients eighteen years of age)

I, _______________________________________ authorize Piedmont Pediatrics to share access to my medical information with the following person(s). This includes (but is not limited to) the patient portal, verbal confirmation of my treatment and or lab results over the phone.

Name	**Phone**	**Relationship to You**

By signing on this line, you are authorizing those noted above access to your records.

Signature: ______________________________ Date:_____________

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DECLINE OF PARENTAL AUTHORIZATION

I, ____________________________________ do NOT authorize Piedmont Pediatrics to share access of my medical information with anyone.

Signature ____ Date ________