Patient Information Consent Form

Patient Name: _____DOB: _____

I, _____, give Kaleidoscope Kids providers and staff permission to speak with or provide records to the following people regarding my/my child's health status, including diagnosis, treatment options, plans and payment for health services received from Kaleidoscope Kids.

This consent is valid until such time I provide Kaleidoscope Kids with written revocation of it. **Please list both parents, step-parents, and others with legal guardianship or custody of the child for whom consent is allowed.** Kaleidoscope Kids will not be involved in custody disputes.

Meredith A. Byington, MD, P. A./ Kaleidoscope Kids staff may speak with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent/ Guardian Signature: _____ Date: _____

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