

Print Client Name:

Client Signature: Date:



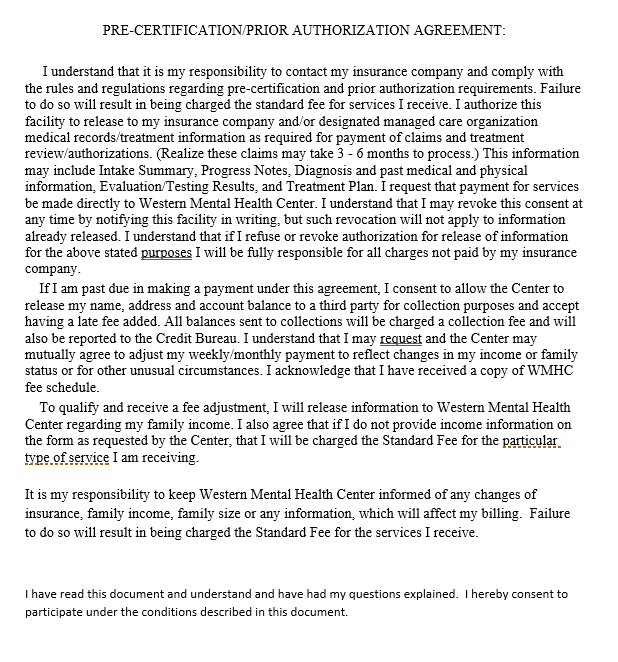
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Parent or Legal representative signature Relationship Date



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Witness Date

Print Client Name:

Client Signature: Date:

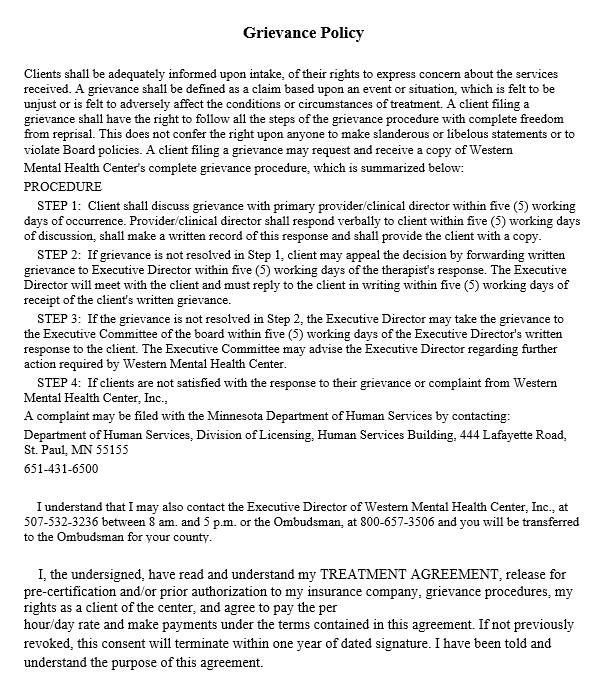


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Parent or Legal representative signature Relationship Date



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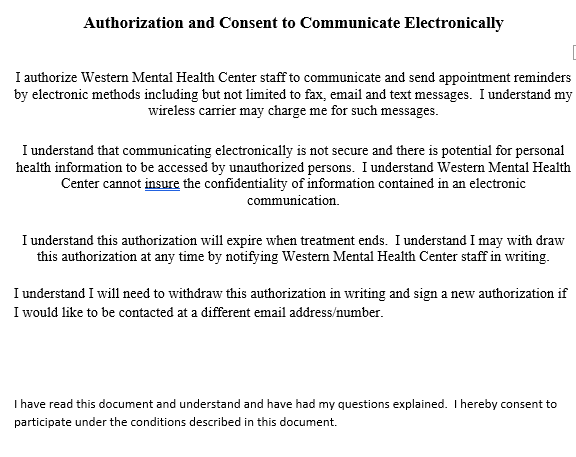
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Parent or Legal representative signature Relationship Date



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Witness Date



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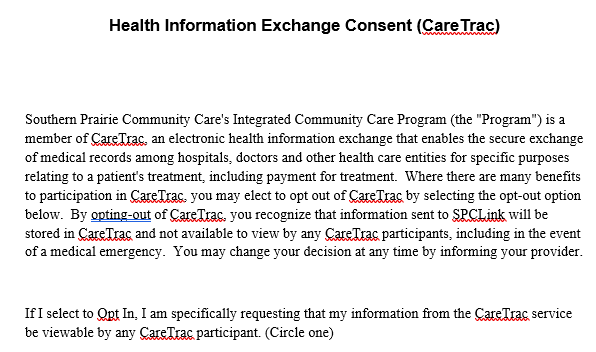
Parent or Legal representative signature Relationship Date



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Witness Date

Top of Form



Opt In Opt Out (check preference)



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Parent or Legal representative signature Relationship Date



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Witness Date

**Consent to share medical information**

Yes No

Consent Period:

Exclusions Yes or No

If Yes select:

Check the box of the section(s) you wish to exclude

|  |  |  |
| --- | --- | --- |
| Allergies   Clinical Instructions   Encounters   Medications   Medications Administered   Patient Decision Aids   Pending Diagnostic Tests   Referrals to Other Providers   Care Plan   Cognitive & Functional Status | Immunizations   Procedures   Smoking Status   Care Team   Encounter Diagnosis & Problems   Lab Tests & Results   Reason for Visit/Chief Complaint.   Vitals   Future Appointments | Future Tests   Referrals to Other Providers   Assessment   Goals   Health Concerns   Medical Equipment   Problems   Results   Social History |

I have read this document and understand and have had my questions explained. I hereby consent to participate under the conditions described in this document.

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Parent or Legal representative signature Relationship Date



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Witness Date