 

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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Witness Date Print Client Name:

Client Signature: Date:



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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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Witness Date