GENERAL CONSENT

Part I *(For Parent of a Minor)*

I would like my child/children, _____, to receive regular
Patient's Name(s) & Date(s) of Birth
medical care at Gahanna Pediatrics, Inc. but I might not be able to accompany him/her/them. In the event my child/children is/are brought to Gahanna Pediatrics, Inc. for well-care or for a sick visit by an adult other than a parent or legal guardian, I give consent for my child/children to receive medical care including routine childhood immunizations.

_____ _____
Signature of Parent/Guardian *Witness (Gahanna Ped. Staff)*

_____ _____
Date *Date*

Part II *(For All Patients)*

I give consent for Gahanna Pediatrics, Inc. to release the immunization record of,

_____, if required by a preschool, daycare, school,
Patient's Name(s) & Date(s) of Birth
another doctor's office or the health department.

_____ _____
Signature of Parent/Guardian/Adult Patient *Witness (Gahanna Ped. Staff)*

_____ _____
Date *Date*

Note: If you do not give consent, you will be asked to sign each time the shot record is requested by anyone other than a parent/legal guardian or self (if patient is 18+).

Part III *(For Patients 18 Years and Older)*

I give consent for Gahanna Pediatrics, Inc. to release medical information to my parent(s)/guardian(s),

_____, upon request.
Name of Parent(s)/Guardian(s)

_____ _____
Signature of Adult Patient *Witness (Gahanna Ped. Staff)*

_____ _____
Date *Date*