DESIGNATED REPRESENTATIVE

Patient Name:_________________________________Date of Birth:_______________

Parent/LegalGuardian:____

I hereby give my consent for the following designated representative to discuss my child's medical condition with Dr. Charish L. Barry.

Discussion may include:
______All medical information
______Information limited to the following:
____

Designated Representative:

Name: ____
Relationship to Patient: ____

This authorization expires on: ____

____
Patient or Parent/Legal Guardian Signature **Date**

1525 State Street, Suite 206, Santa Barbara, CA 93101 *(805) 845-1221*