Petite Pediatrics

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(s):

Name: _____
Relationship to Patient: _____

Name: _____
Relationship to Patient: _____

Name: _____
Relationship to Patient: _____

Name: _____
Relationship to Patient: _____

This consent by proxy remains in effect until I rescind it, in writing, at some future date.

_____

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

510 W. Pueblo St, Santa Barbara, CA 93105 (805) 845-1221

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