Mountain View Pediatrics
159 Margaret St - Suite 100
Plattsburgh, NY 12901
Phone: (518) 324-2040
Fax: (518) 324-2041

Informed Consent
Release of Information

I, ____, give permission to Mountain
(Name of Parent/Guardian)

Pediatrics to give and release information to the following people and/or business for my child______________________________, Date of birth: ____________________:
(Child's Name)

Name: __________________________ Relationship: _____________________

Name: __________________________ Relationship: _____________________

Name: __________________________ Relationship: _____________________

Name: __________________________ Relationship: _____________________

Signed: __________________________ Date: ____________________

* This consent form may be rescinded at any time by the parent and/or guardian.

** This form is good for one year and then must be updated to be valid.