



Patient Information Consent Form

Consent Form

I, _____, give Kaleidoscope Kids providers and staff permission to speak with or provide records to the following people regarding my or my child's health status, including diagnosis, treatment options, plans and payment for health services I receive from Kaleidoscope Kids.

This consent is valid until such time I provide Kaleidoscope Kids with written revocation of it. **Please list both parents, step-parents, and others with legal guardianship or custody of the child for whom consent is allowed.** Kaleidoscope Kids will not be involved in custody disputes.

Meredith A. Byington, MD and staff may speak with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____