I understand and acknowledge that as of my 18th birthday, my parents and / or guardians will no longer be permitted access to my medical records, information, providers or appointment status without my specific written permission.

I give the below-named individuals(s) permission to act on my behalf with NO limitations, including sexual and mental health and substance use history. I understand that they may contact any physician or member of the staff at Sweetgrass Pediatrics to schedule appointments, discuss my healthcare/financial/insurance details, and access my complete medical records. THEY HAVE NO RESTRICTIONS.

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

This content is valid from the date signed. I understand that I can withdraw this consent at any time in writing.

Patient Name

Date of Birth

Patient Phone Number Patient Email

Patient Signature

Date Signed