I _____, authorize the physicians and staff at SF Bay Pediatrics to discuss issues regarding my health with my parent(s) excluding the following:

Please, check the applicable boxes.

Specified exclusions:

- ☐ **Reproductive Health**
- ☐ **Substance Use**
- ☐ **Other: _____**

Or

- ☐ **No Exclusions:** *The practice may discuss all issues.*

Please list the names of people you are allowing to see your medical records:

Name: _____ Relation: _____
Name: _____ Relation: _____

Date: _____

Signature: _____

Print Name: _____

Authorization expires on: _____

Your cell phone number where the physicians/staff can call or leave a message regarding your health information: _____