

Please list the name and date of birth of all children in your family.

Patient Name: ______Date of Birth: _____

Patient Name:		Date of Birth:	
Patient Name:		Date of Birth:	
	My Kids Patient P		
Access to records is available for all cl their record automatically becomes additional release form.			
Please list the name and	email of the parent/guard	ian that would like access t	o the patient portal:
Parent/Guardian Nan	ne:		
Email address PLEASE PRIN	T CLEARLY:		
Au	thorization for (Other Caregivers	6
The person listed below is designated physician or provider at Bloom Pedinecessary anesthetics, medical treaperforming of whatever procedures in the sunderstood that this authorization	iatrics for my minor child. Sucletment, test, X-ray examinatio may be deemed necessary or adv	n consent may include but is nns, transfusions, injections, imvisable.	ot limited to, administration o munizations or drugs and the
given to provide the authority to con of their best judgement, may deem a undersigned.	sent thereto as our said agent ar	nd the above-named child's atte	nding physician, in the exercise
The undersigned hereby authorize (p	erson other than parent/guardi	<mark>an</mark>):	
Name: Relati		ationship to patient:	
Name:	me: Relationship to patient:		
lame: Relationship to patient:			
My signature below certifies that all o	of the above information is true	and accurate.	
Signature of parent/guardian	Printed name of pare	nt/guardian	 Date
For office use only:			
Date account set-up		Initials	