

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\* This consent form may be rescinded at any time by the parent and/or guardian.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