Janet R. Casey, M.D.
Alice L.Taylor, M.D.
Kate Shand, PA-C, IBCLC
Kristin Campe, PA-C, LCSW

Consent to Communicate Form

I give legacy Pediatrics permission to discuss ______________________________ DOB____________ medical information with the individuals listed below. I understand that I can revoke this consent at any time.

Name	Relationship	Phone #

Legal Guardian Signature if under 18yr ______________________________

Patient Signature if over 18yr ______________________________

Date ____________________

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