SINDU PILLAI, M.D.
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CONSENT TO SHARE/DISCUSS PRIVATE HEALTH INFORMATION

I _____ give consent to Sindu Pillai, M.D. to discuss my child's condition with any Doctors/Educators. I also permit contact via message machine or family member to the following phone number: _____ regarding my child's health.

I understand that this agreement does not serve as a medical release of records and that Dr. Sindu Pillai and/or staff can refuse to discuss private health information if believed that is in the best interest of the patient.

Child's Name _____
Legal Guardian Signature_____
Date _____