

Minor consent form

Tri-Valley Pediatrics, Inc.

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I, _____, DOB _____ hereby authorize my
family/guardian _____ and _____ to
have full access to ALL of my medical records including but not limited to labs, visit notes, all
confidential notes, radiology and consents.

I am aware of my right as an adolescent in state of California to have the right to confidentiality
and hereby waive this right by giving my parents/guardian FULL ACCESS TO ALL MY MEDICAL
Information.

Signature _____

Date: _____