Washington Pediatric Associates, PC

AUTHORIZED RECIPENTS PRIVACY PRACTICE ADDENDUM

_____ _____

CHILD'S NAME **DOB**

NAME	**INDIVIDUAL/FACILITY**	
_____	_____	**ADD/REMOVE**
_____	_____	**ADD/REMOVE**
_____	_____	**ADD/REMOVE**
_____	_____	**ADD/REMOVE**
_____	_____	**ADD/REMOVE**
_____	_____	**ADD/REMOVE**
_____	_____	**ADD/REMOVE**
_____	_____	**ADD/REMOVE**

I _____, AUTHORIZE CHANGES NOTED ABOVE
PARENT NAME

_____ _____

Signature of Parent Date