



Parental Consent for Adult Child

GUARANTOR'S AGREEMENT

Date	Account #

I give permission for Primary Care Partners to add the following individual to my account:

Name	DOB	Relationship to Patient
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I acknowledge that they are 18 years of age or older and considered an "adult". I accept financial responsibility for all charges incurred by this individual while on this account.

Signature

Print Name	Phone Number
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Address	City	State	ZIP Code
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PATIENT'S CONSENT TO RELEASE MEDICAL INFORMATION

Date	Account #

I give permission for Primary Care Partners to share my personal medical information with the following individuals:

Name(s)	Relationship to Patient(s)
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Signature

Print Name	Phone Number
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Address	City	State	ZIP Code
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<p>PCP Care Village 3150 N 12th Street Grand Junction, CO 81506</p> <p>Western Colorado Pediatrics 970-243-5437</p> <p>Family Physicians of Western Colorado 970-245-1220</p>	<p>Tabeguache Family & Sports Medicine 970-256-5201</p> <p>Diagnostics & Mammography 970-241-6014</p> <p>Physical Therapy Specialty Center 970-241-5856</p> <p>Nutrition Therapy & Wellness 970-255-1576</p>
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<p>After-Hours Clinic 3150 N 12th Street Grand Junction, CO 81506</p>	<p>DOCS on Call 970-255-1576</p>
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<p>Wellington Location 1120 Wellington Ave Grand Junction, CO 81501</p>	<p>Western Colorado Physicians Group 970-241-6011</p>
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<p>Fruita Location 455-456 Kokopelli Blvd Fruita, CO 81521</p> <p>Western Colorado Pediatrics 970-243-5437</p> <p>Red Canyon Family Medicine 970-256-5285</p>
