

# Pediatric Associates of Plano

## Consent to Release Patient Health Information

I authorize Pediatric Associates of Plano to leave a detailed message on voice mail at my home, cell and business telephone numbers with all appointment and medical information including test results and billing issues.

           **Release this information to both parents and the following family members.**

Please specify name and & relationships

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Children(s) name(s) and birthdate(s)

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Parent Name

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Date

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Parent Signature