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

_____

_____

_____

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

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Parent Name Date

_____

Parent Signature