McKinney Pediatrics

1872 N. Lake Forest Dr. McKinney, Texas 75071 T: 972.548.0758 F: 972.548.0425

Permission for Medical Care & Release of Information

I, _____hereby authorize the physicians and staff of McKinney Pediatrics, PA to give the following people information about my child's health and well-being. Also, in my absence, any persons listed below can accompany my child to the office for medical care.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

The following information may be given:

	People listed above	**Voicemail**
Appointment Time	Yes or No	Yes or No
Test/Lab Results	Yes or No	Yes or No
Medications	Yes or No	Yes or No
Procedures	Yes or No	Yes or No
Any info. not listed above regarding my child's health	Yes or No	Yes or No

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. Until written notification is given, this request will remain valid.

Patient's Name: _____ Date of Birth: _____

Signed: _____ Date: _____

(Parent/Legal Guardian)