Medical Records / Patient Visit Approval Authorization Form

Permission to bring child to appointments:

I ______________________ as the legal parent/guardian of ___________________ authorize the following people in addition to legal parent/guardian to bring the above named child to any and all appointments at the Siskin Center for Developmental Pediatrics.

Name	Relationship to patient	Phone Number

Permission to give information about this child to others:

I ______________________ as the legal parent/guardian authorize the Siskin Center for Developmental Pediatrics to discuss above named child's medical information with the following people in addition to other legal guardians.

Name	Relationship to patient	Phone Number

This authorization will be valid until the legal parent/guardian requests a change in writing and / or the patient is no longer being treated / evaluated at the Siskin Center for Developmental Pediatrics. This form covers Medical Services, Behavioral Services, and Therapy services provided at the Siskin Center for Developmental Pediatrics.

_________________________________ _____________________
Guardian Name Date

_________________________________ _____________________
Staff Witness Date

UT-COM, Department of Pediatrics-Division of Developmental Behavioral Pediatrics
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