Preferred Pediatrics

I hereby grant permission for the physician and/or staff of Preferred Pediatrics to release medical information to: Parent: □ YES □NO To release medical information to the parent (if child is a minor)/self (if patient is 18 or older), Preferred Pediatrics may: Call my place of employment. (Results will not be left by message) □ YES Leave medical information on my identifiable voicemail? b. □ YES \sqcap NO c. Only call me directly by phone at my residence. I understand if I am unable to receive my call that a message will be left requesting that I call the office to receive the information. □ YES \square NO Other family members: $\square YES$ □NO (If yes, please specify) 1. Name Relationship **Phone Number** Name Relationship **Phone Number** The following individuals have my permission to bring my child to his/her appointments in my absence: 3. Name Relationship **Phone Number** Name Relationship **Phone Number** Name of Patient (print): Name of Parent (print):

Signature of Parent: ______ Date: _____