Medical / Financial Information Disclosure

Parent / Guardian Information

Name:___________________________ Cell: __________________________

Relationship to patient:___________ Work:__________________________

Email:__________________________

Name: ___________________________ Cell:___________________________

Relationship to patient:____________ Work:__________________________

Email: __________________________

I, ______________________________, the undersigned, hereby authorize North Florida Pediatric Associates, P.A., its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s). The individuals listed below are involved in my child's care and have authorization to talk to our staff on the phone and/or seek medical care and authorize treatment including vaccines.

Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized.

☐ **At this time, I do not want to authorize anyone other than parent/guardian.**

Name: ________________ Relationship to Patient: _____________ Telephone:_____________

Name:_________________Relationship to Patient:_____________ Telephone:______________

Name:_________________Relationship to Patient: _____________Telephone: _____________

Name: ________________ Relationship to Patient: _____________Telephone: _____________

I understand that authorization to anyone other than myself and child's other parent is voluntary and I can revoke authorization at any time:

Authorized by: ___________________________________ ________________________________

(Guardian Signature) (Print Guardian Name)