Albemarle Pediatrics

Authorization for Patient Information Release and Consent for Treatment of Minor Child

Date: ____________________

Patient First Name: ____________________________

Patient Last Name: _____________________________

Patient DOB: _______________________

I, being the parent or guardian of __________________________, do hereby request and authorize Albemarle Pediatrics and their staff to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment. Below is a list of individuals who have permission to bring my child in for treatment, obtain healthcare information, and pick up prescriptions/forms. Healthcare information includes but is not limited to: diagnostic results, medical treatment, medications, appointments, and medical history.

______________________________________	______________________________________
Name of Biological Mother	**Name of Biological Father**

______________________________________	______________________________________
Name of authorized Individual	**Relationship to patient**

___ Treatment ___ Healthcare Information ___ Prescriptions ___ Forms

______________________________________	______________________________________
Name of authorized Individual	**Relationship to patient**

___ Treatment ___ Healthcare Information ___ Prescriptions ___ Forms

______________________________________	______________________________________
Name of authorized Individual	**Relationship to patient**

___ Treatment ___ Healthcare Information ___ Prescriptions ___ Forms

______________________________________	______________________________________
Name of authorized Individual	**Relationship to patient**

___ Treatment ___ Healthcare Information ___ Prescriptions ___ Forms

I acknowledge that I have read and understand Albemarle Pediatrics ADHD Policy.

____

Signature of Individual or Patient's Representative Date

I am the individual named below, or I am authorized to act on behalf of the individual to consent and to sign this document. I understand that if I wish to change, add, or delete anyone from the above list, I will need to provide written notification to Albemarle Pediatrics. I have read and understand the information on this form.

____

Signature of Individual or Patient's Representative & Date

____

Print Name of Individual or Patient's Representative

____

Signature of Witness

Describe Representative's authority to act on behalf of Individual:

____

(attach a copy of any documentation of Representative's authority)