PGV PEDIATRICS, P.A.

3417 GASTON AVENUE, SUITE 845

DALLAS, TX 75246

PHONE: (214)823-2552

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DISCLOSURE OF MEDICAL/FINANCIAL INFORMATION TO FAMILY MEMBERS/FRIENDS

Patient Name: ____ **DOB:** ____________________

In our effort to adhere to HIPAA guidelines, PGV Pediatrics, P.A. needs your authorization to release medical/financial information connected to your child's/your care. Please complete the information below so that we may release any necessary information to your family member(s) or friends (this does not apply to patient or parents).

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Name: ________________________________ Relationship: _____________________

Contact information: ____

Type of information that PGV Pediatrics, P.A. can provide to them:
O Medical **O** Financial **O** Both

Name: ________________________________ Relationship: _____________________

Contact information: ____

Type of information that PGV Pediatrics, P.A. can provide to them:
O Medical **O** Financial **O** Both

Please check box below if you **DO NOT** want this information to be released to anyone other than the patient or parents.

O Please **DO NOT** release this information

_______________________________________ _______________________
Signature of Parent/Patient Date

_______________________________________ _______________________
Witness Name Printed Date

____
Witness Signature