CONSENT FOR TREATMENT
AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Pecan Tree Pediatrics to administer such care and treatment for (patient) _____ as is medically necessary and as is set forth in the development plan of treatment. I also authorize Pecan Tree Pediatrics to release any medical information acquired in the course of my child's examination or treatment, to any facility (including other physicians, laboratory, hospital or ancillary providers) to which my child may need to be referred. I further authorize Pecan Tree Pediatrics to release any medical information determined in the course of my child's examination or treatment required to process medical claims, to my insurance carrier.

_____ _____
Parent/Guardian Signature Date

CONSENT FOR CARE FORM

I _____ give permission for:

_____ _____
(Name) Relationship to Child

_____ _____
(Name) Relationship to Child

_____ _____
(Name) Relationship to Child

_____ _____
(Name) Relationship to Child

to bring my child _____, for his/her appointments. Please give them any information and/or prescriptions that may be needed.

In case of emergency, I can be reached at _____.

_____ _____
Parent/Guardian Signature Date