Pediatric Medical Information and Treatment Release Form

Patient Name:_______________________________ DOB:____________

Please list the names below that may bring your child/children to see a provider at High Mountain Healthcare, LLC for treatment in your absence. If you do not have a person listed and they bring child for an office visit, we will have to reschedule the appointment.

Name______________________________Relationship_________________

Name______________________________Relationship_________________

Name______________________________Relationship_________________

Name______________________________Relationship__________________

Information on my child may be released to:

Parent(s)____

Other____

___I authorize messages regarding my childs medical care to be left on any phone number that I have provided.

___I authorize the release of information including the diagnosis, records, claims information, and examination rendered to my child.

This release of information will remain in effect until terminated by me in writing.

By signing below I am confirming that I am the patient, legal guardian, or POA of the above named patient.

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Printed Name and Signature: Date: