Roswell Pediatric Center, PC

Patient Authorization to Communicate with Others

I authorize Roswell Pediatric Center, PC to communicate with the following person(s) on my behalf. I authorize the individual(s) listed below to seek and obtain treatment for my child/children. This authorization will continue until revoked in writing by me.

I authorize:______ Full disclosure ______ Limited information to be released (please specify restrictions)

Restrictions:____

____

Patient Name (printed)	DOB	Parent or Patient Signature (*if 18 or older*)	Date
Patient Name (printed)	DOB	Parent or Patient Signature (*if 18 or older*)	Date
Patient Name (printed)	DOB	Parent or Patient Signature (*if 18 or older*)	Date
Patient Name (printed)	DOB	Parent or Patient Signature (*if 18 or older*)	Date

Please list name of Individual(s) you are authorizing release of information to:

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

October 2012