Medical Disclosure Authorization

I hereby certify that I am the patient or the legal parent/guardian of:

Patient #1. _____
Patient #2. _____
Patient #3. _____
Patient #4. _____

In addition, I authorize the following person(s) to act as my legal proxy with regard to disclosure of confidential medical information and **authorization of treatment** for the above mentioned patient. I also agree to waive, on behalf of myself, and any of the person(s) listed below, all provisions of law relating to such.

Name:_____ Telephone:_____ Relationship:_____
Name:_____ Telephone:_____ Relationship:_____
Name: _____ Telephone:_____ Relationship:_____

Medical Information/Results May Be Released To:

Name:_____ Telephone:_____ Relationship:_____
Name:_____ Telephone:_____ Relationship:_____
Name: _____ Telephone:_____ Relationship:_____

Financial Information May Be Released To:

Name:_____ Telephone:_____ Relationship:_____
Name:_____ Telephone:_____ Relationship:_____
Name:_____ Telephone:_____ Relationship:_____

I understand that I have the right as the legal parent/guardian of the above mentioned child to amend this proxy listing at any time upon written notification to Stepping Stone Pediatrics.

Signature: _____Witness:_____

Messages:
Please reach me at the following preferred phone number: _____
If I am unavailable to answer calls at this number (please check one):
( ) You may leave a detailed message.
( ) Please leave a message asking me to return your call.
( ) Please do not leave any message.
( ) Other_____