Today's Date: _____

Patient Name: _____

Patient Date of Birth: _____ Patient Phone #: _____

I understand since I am 18 years of age or older, I must give my written consent to allow a personal representative to receive my medical information, schedule and/or cancel an appointment and/or discuss my financial account.

My signature, below, authorizes Pediatricians of Dallas to release the following to:

Printed Name of Personal Representative (s): _____

[ ] Receive my medical information

[ ] Schedule and/or cancel an appointment

[ ] Discuss my financial account

I understand this authorization stands until I submit a written request to cancel said authorization.

Date: _____ Signature: _____

Pediatricians of Dallas – 8325 Walnut Hill Lane, Suite 225, Dallas, TX 75231

214-691-3535/Fax 214- 691-0404