Today's Date: _____/_____/_____

Patient Name _____

CONSENT for TREATMENT of a MINOR

I, the Parent or Guardian of said patient, who is a minor, authorize TLC Pediatrics and all persons acting as agents thereof and all physicians to who said minor is referred for medical treatment, to furnish all forms of diagnostic, preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to TLC Pediatrics.

AUTHORIZATION AND RELEASE

I authorize TLC Pediatrics to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to TLC Pediatrics insurance benefits otherwise payable to me.

Medical Records
There is a $10.00 charge for copies of medical records to disc and a $25.00 charge for paper copies. This fee must be paid prior to the release of the records. Please allow up to 30 days to process your request. All original medical records are property of TLC Pediatrics, PLLC and only copies will be given.

There is no charge for physician-to-physician release.

There is a $25.00 charge for all approved FMLA requests

School Forms, Camp Forms, Day Care Forms, etc. - Please allow 72 hours to process these forms. When possible please bring the forms to your scheduled visit.

I have read and understand the above policies and procedures set forth by TLC Pediatrics.

X _____ _____
Signature of Responsible Party Date

X_____
Print Name of Responsible Party

A photocopy or scan of this authorization shall be considered as effective and valid as the original

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