ADVANCED PEDIATRICS

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RELEASE OF INFORMATION

I hereby give permission for Advanced Pediatrics & _____ of
(Specialist/Provider Name)

_____ at _____
(Practice/Group Name) *(Email Address & Phone Number)*

to coordinate and share information with each other regarding my child's care.

Child(ren)'s Name(s): ***Date of Birth:***

_____

_____

_____

I acknowledge the fact that coordination of care is a billed service, and I am responsible for any copayment, coinsurance, or deductible as it applies to my insurance plan.

_____

Parent's Printed Name ***Parent's Signature*** ***Date***