PEDIATRIC ASSOCIATES OF SPRINGFIELD, INC.

*Turner Center * 1000 East Primrose * Suite 560*
Springfield, MO   65807
*Phone: 417-882-1600 * Fax: 417-631-0119*

Please fill out the following information regarding the care of your children.
Thank you,
Pediatric Associates

*Patient Name:*____ *DOB:*__________

Please list the names of people you may wish us to share information with regarding your child's medical care and billing information.

Name of person you wish to share information	*Relationship*
____	____________________________
____	____________________________
____	____________________________
____	____________________________
____	____________________________
____	____________________________

I also give permission to Pediatric Associates of Springfield, Inc. to discuss my child's medical care with their school nurse or athletic trainer if he/she calls our office.

________ ______
Yes   *No*

In order to protect the confidentiality of your child's medical records, we ask that you sign and date this form.

____ ____________________________
Signature of Parent/Guardian   *Date*

09-10-2012