Windhaven Pediatrics
6300 West Parker Rd. #324
Plano, TX 75093
972-403-5437 Fax 972-403-5438

Authorization For Treatment

I hereby authorize Windhaven Pediatrics and any such assistants or physicians as he/she designates to render any necessary, or advisable treatment to my children named below:

I understand that the physician may require the usage of x-rays, lab studies, and/or surgery as deemed medically necessary.

I authorize any advisable treatment in the event that I am unable to be contacted. If this should occur, please recognize Mr./Mrs./Ms. ____ as my representative to make medical decisions deemed necessary.

Telephone/Communication Release

I wish to be contacted in the following manner:

OK to leave detailed message at the following phone numbers:

- ○ Home ____________________________
- ○ Cell ____________________________
- ○ Work ____________________________

I authorize Windhaven Pediatrics to disclose and discuss any information related to my child's medical condition(s) or any other such related information to the following family member(s), relative(s):

______________________	________________________	___________________
Name	Relationship	Phone#
______________________	________________________	___________________
Name	Relationship	Phone#
______________________	________________________	___________________
Name	Relationship	Phone#

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to disclosure of any medical information. I authorize release of this information to other healthcare providers associated with my child's care to facilitate further healthcare treatment.

____
Parent/Guardian (Print Name) Date

____
Signature