



Kimberly M. Rosdeutscher, M.D.  
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Name: \_\_\_\_\_

Date: \_\_\_\_\_

Children's Medical Group  
Parental Permission For Medical  
Treatment and Clinical Information

Please list the people that may bring your child to our office for treatment or receive **any** information about your child. (This will include appointments, lab results, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please list the people who **cannot** bring your child for appointments or obtain any information regarding your child. **In the case of custody issues, court papers must be provided to the office.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

In order to ensure your child's privacy in regards to releasing any information from this office, we ask that you provide us with a code that you and others that you designate can give to the office staff when calling to inquire about appointment times, lab work, or when speaking to the triage nurse. (This can be a four digit number or a word or phrase that you can remember)

Code \_\_\_\_\_

\_\_\_\_\_  
Parent Signature