



Centennial Pediatrics, PC
Consent for Treatment
Authorization for Release of Information

I authorize Centennial Pediatrics, PC to administer such care and treatment for (patient) _____ as is medically necessary and as is set forth in the development plan of treatment. I also authorize Centennial Pediatrics, PC to release any medical information acquired in the course of my child's examination or treatment, to any facility (including other physicians, laboratory, hospital or ancillary providers) to which my child may need to be referred. I further authorize Centennial Pediatrics, PC to release any medical information determined in the course of my child's examination or treatment required to process medical claims, to my insurance carrier.

Parent/Legal Guardian Signature

Date

Provider for Centennial Pediatrics, PC

Date