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Julia Ann Sherwood, M.D. Sam J Denney, Jr., M.D. Gordon H. Meador, M.D.
Samuel A. Smith, M.D. Amanda H. Cook, M.D. Laura A. Barron, M.D. M. Adam Adcock, M.D.

List Child/Children's Names and Birthdays:

_____

_____

_____

My signature below authorizes the following persons to bring my child/children in for treatment at the Children's Clinic without my presence:

Person's Name	Relationship to Patient	Phone Number

I give permission to the physicians at The Children's Clinic and their staff to disclose those listed above my child's Protected Health Information (PHI) including but not limited to treatment, testing and diagnosis (including picking up prescriptions and completed medical forms). I understand that those listed above may make decisions regarding the recommended treatment and testing by the physician and must be responsible for relaying details of the services rendered during my child's visit back to me. I further understand that I may revoke this authorization at any time with written notice to The Children's Clinic, PLLC.

Guarantor's Signature: _____ Date: _____

Guarantor's Name (Print): _____

Relationship to Patient: _____

COMPLETE OTHER SIDE