Ballentine Pediatrics, LLC
11134 Broad River Road Suite D Irmo, SC 29063
Office 803-732-0920 Fax 803-227-2759

Medical Consent and Information Release

I, ____ (Parent or Legal Guardian) hereby agree that the Providers of Ballentine Pediatrics will provide medical care for my child/children listed below:

Name	DOB	Name	DOB
Name	DOB	Name	DOB
Name	DOB	Name	DOB
Name	DOB	Name	DOB

Please list all individuals (other than parents or legal guardians) who you have given authorization to bring the above listed child(ren) in for medical treatment, or to pick up prescriptions, receive lab results and or medical information pertaining to treatment or care, schedule and obtain appointment information, give and receive insurance and account information.

Name	Relationship to Patient	Phone/Contact Information
Name	Relationship to Patient	Phone/Contact Information
Name	Relationship to Patient	Phone/Contact Information
Name	Relationship to Patient	Phone/Contact Information
Name	Relationship to Patient	Phone/Contact Information

I hereby authorize Ballentine Pediatrics to: (1) release any information necessary to insurance carriers regarding the above listed child(ren)'s illnesses and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Name	**Relationship to Patient(s)**	**Date**

June 2015