PEDIATRIC INSTITUTE FOR EPILEPSY
AND NEUROLOGICAL DISORDERS

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AUTHORIZATION TO SHARE MEDICAL INFORMATION

Child's Name: _____

Child's Date of Birth: _____

I, _____ authorize the following people to
Parent/Legal Guardian's Name

bring my child to Pediatric Institute for Epilepsy and Neurological Disorders for treatment by Rashmi Gupta, M.D. and her staff. I also authorize for the following people to obtain financial information, prescription refills and forms to be completed for my child.

Name: _____ Rel. to Child_____ DOB: _____ Phone: _____

Name: _____ Rel. to Child_____ DOB: _____ Phone: _____

Name: _____ Rel. to Child_____ DOB: _____ Phone: _____

Name: _____ Rel. to Child_____ DOB: _____ Phone: _____

Name: _____ Rel. to Child_____ DOB: _____ Phone: _____

Name: _____ Rel. to Child_____ DOB: _____ Phone: _____

This agreement remains in effect until we receive written notice from you of any changes.

_____ _____

Signature of Parent /Legal Guardian **Date**