St. Louis Pediatric Associates, Inc.
226 S. Woods Mill Rd. 32W ◆ Chesterfield, MO 63017
Phone (314) 576-1616 ◆ *Fax* (314) 576-5271

Medical / Financial Information Disclosure

Date: _____

Child(ren) Name (s): _____ _____

_____ _____

Name: _____ Home: _____ ok to leave message YES NO
Relationship to patient: Mother Work: _____ ok to leave message YES NO
Cell: _____ ok to leave message YES NO

Name: _____ Home: _____ ok to leave message YES NO
Relationship to patient: Father Work: _____ ok to leave message YES NO
Cell: _____ ok to leave message YES NO

I, _____, the undersigned, hereby authorize St Louis Pediatric Associates, Inc., its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s). The individuals listed below are involved in my child(ren)'s care and have authorization to talk to our staff on the phone and/or bring my child(ren) into the office.

Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized.

☐ **At this time I do not want to authorize anyone other than parent/guardian.**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I understand that authorization to anyone other than myself and child's other parent is voluntary and I can revoke authorization at any time:

Authorized by: _____ _____
(Parent Signature) (Print Parent Name)