Patient Name: _____ Patient DOB: _____ Acct# _____ Date: _____

Capital Area Pediatrics
your neighborhood pediatrician

Authorization for Developmental Behavior Services
CONSENT FOR RELEASE OF MEDICAL INFORMATION TO SPECIALIST

I give Dr. _____ permission to speak with the following professionals:

Professional:

Name: _____ Specialty: _____

Email: _____ Telephone: _____

Name: _____ Specialty: _____

Email: _____ Telephone: _____

Name: _____ Specialty: _____

Email: _____ Telephone: _____

School:

☐ YES, please contact school (complete below)

☐ NO, do not contact school (do not complete below)

Name of school: _____

Contact person and title: _____

Email: _____ Telephone: _____

Signature of parent: _____ Date: _____

Please bring copies of all relevant paperwork to your appointment (i.e. Medical records, laboratory results, IEP reports, assessments, etc.)

We look forward to meeting you.
Polly Panitz, M.D.