Washington University Clinical Associates

Robert D. Spewak, M.D. Jerome H. O'Neil, Jr. M.D. Karen L. Whiteside, M.D. Sarah E. AuBuchon, M.D.
Shilpa T. Menolascino, M.D. Andrea N. McCulloch, R.N., C.P.N.P Veronica J. Wright, R.N., C.P.N.P

Sharing of Medical/ Financial Information

Child/Children's Name(s) & Date(s) of Birth _____ _____

_____ _____

_____ _____

Medical/Financial Information Disclosure

☐ I authorize SOUTHWEST PEDIATRICS- WUCA to call the primary phone number listed below and leave a message regarding appointment reminders, insurance items, and my child/children's clinical care, including lab and imaging results.

☐ I authorize SOUTHWEST PEDIATRICS-WUCA to use and/or disclose pertinent health information about my child/children for school, camp or sport forms and securely fax such information as requested by school or a parent/guardian.

The phone number provided below is the best number for SOUTHWEST PEDIATRICS-WUCA, to contact me and will be listed as the primary number on my child/children's account.

Primary Phone Number: _____ ☐Home ☐Mom Cell ☐Dad Cell

Sharing of Medical/Financial Information

I authorize SOUTHWEST PEDIATRICS-WUCA, its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s). The individual(s) listed below are involved in my child/children's care and have authorization to talk to our staff on the phone and/or bring my child/children 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: _____

I understand that authorization to anyone other than myself is voluntary and I can revoke authorization at any time.

_____

(Parent/Guardian Signature) (Printed Name) (Date)