PEARSALL PEDIATRICS

Gurney F. Pearsall, Sr. M.D. P.A.
2010 Naomi Street Suite C Houston, Texas 77054
office (713) 790-9265 fax (713) 790-1006
www.PearsallPeadiatrics.com

AUTHORIZATION TO RELEASE INFORMATION

Date:_____

Patient Name:_____ Date of Birth:_____

I hereby authorize the above physicians to release any information acquired in the course of my examination or treatment.

_____

Signature: Patient or Parent/Legal Guardian of Minor

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the above physicians, the surgical and or medical benefits, if any, otherwise payable to me for his services, but not to exceed the reasonable and customary charges.

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Signature: Insured Person