



**Segal Family Medicine Center, P.A.**  
 6537 Preston Road  
 Plano, TX 75024  
 Phone: 972 379-2096 · fax 972 379-2054

**PARENTAL CONSENT FOR THE HEALTH TREATMENT  
 OF A MINOR**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
 Month / Day / Year

Name of person with allowed authority: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

As the parent or legal guardian with the authority to consent on behalf of the minor patient named above, I hereby give my consent for the minor to receive treatment from Segal Family Medicine Center. I consent to all medical, surgical treatment and/or other medical procedures. This may include office visits, diagnostic tests, immunizations, etc. for the above named child, which may be required during my absence. I agree to pay for all services provided to my child in my absence.

This consent serves as permission for treatment by Segal Family Medicine Center. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification. Any questions relating to this form or the proposed treatment can be directed to the Office Manager of Segal Family Medicine Center 972-379-2096.

\_\_\_\_\_  
 Name of person with allowed authority to consent to  
 medical treatment for the minor child

\_\_\_\_\_  
 Relationship to the patient

\_\_\_\_\_  
 Signature of Parent/Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name of Parent/Guardian

\_\_\_\_\_  
 Date



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**AUTHORIZATION OF RELEASE OF INFORMATION FROM SEGAL FAMILY MEDICINE CENTER**

I hereby authorize Segal Family Medicine Center to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company of non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Printed Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Patient Address: \_\_\_\_\_

Dates of Service (if known): \_\_\_\_\_ or  ALL

**Description of information to be released:**

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Emergency Room     | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Admission/Registration | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Records                | _____                                 |
| <input type="checkbox"/> Nurse’s Notes      | <input type="checkbox"/> Physician’s Orders   | <input type="checkbox"/> Laboratory Reports     | _____                                 |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Operative Records    | <input type="checkbox"/> Billing Records        | _____                                 |

**Description of the purpose of the use and /or disclosure:**

\_\_\_\_\_

**The health information described herein shall be released to: (Check ✓ the appropriate category)**

Hospital  Physician  Insurance Company  Attorney  Patient  Other

Name of Entity \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ Fax Number \_\_\_\_\_

City, State, Zip \_\_\_\_\_

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until \_\_\_\_\_ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

\_\_\_\_\_  
Signature of Patient or Patient’s Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient Representative

\_\_\_\_\_  
Relationship to Patient

or \_\_\_\_\_  
Legal Authority (attach supporting documentation)



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**AUTHORIZATION OF RELEASE OF INFORMATION TO SEGAL FAMILY MEDICINE CENTER**

I hereby authorize \_\_\_\_\_

Entity/Person from whom records are requested; include full name

Complete address

City, State, Zip, Telephone, Fax

I hereby authorize the above entity/ person to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company of non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient Address: \_\_\_\_\_

Dates of Service (if known): \_\_\_\_\_ or  ALL

**Description of information to be released:**

- |   |   |   |                    |
|---|---|---|--------------------|
| <input type="checkbox"/> Emergency Room     | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Admission/Registration | _____ other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | Records   | _____              |
| <input type="checkbox"/> Nurses's Notes     | <input type="checkbox"/> Physician's Orders   | <input type="checkbox"/> Laboratory Reports     | _____              |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Operative Records    | <input type="checkbox"/> Billing Records        | _____              |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Radiology Reports    |   |                    |

**Description of the purpose of the use and /or disclosure:**

**The health information described herein shall be released to:**

**Segal Family Medicine Center**  
**6537 Preston Road**  
**Plano TX 75024**

**Phone Number: 972-379-2096**  
**Fax Number: 972-379-2054**

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\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient Representative**

Irwin M. Segal, M.D, C.M. · Aaron P. Segal, M.D. · Stephanie L. Segal, M.D.  
 Anna Segal Practice Administrator, Tawana McKinney Billing/Office Coordinator