Traverse Area Pediatric and Adolescent Clinic

4020 West Royal Drive

Traverse City, MI 49684

Exchange of Information / Permission to Discuss

Patient Name _____

Address _____

_____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

I authorize the providers and staff of Traverse Area Pediatric and Adolescent Clinic to receive and to discuss all health care information necessary for coordination of my child's care/my care, including but not limited to verbal and written communication with the following provider (s).

Physician/Organization Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

I understand this authorization is in effect until I withdraw this request.

Parent/Guardian/Patient (circle one)

Signature_____**Date**:_____

Printed Name:_____