**MEADOWBROOK PEDIATRICS, P.C.**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I authorize Meadowbrook Pediatrics, P.C. access to my child’s medication list electronically (when available) from your prescription plan. The purpose of this authorization is to maintain accurate medication lists and the highest level of care for your child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

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I authorize Meadowbrook Pediatrics, P.C. to transfer electronically my child’s relevant medical information to a specialists, hospital, emergency room or urgent care center for coordination/transition of care.

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Parent/Guardian Signature Date