Consent for Treatment

Authorization for Release of Information

I authorized Cornerstone Pediatrics, PLLC to administer such care and treatment for (patient)_____ as is medically necessary and as is set forth in the development plan of treatment. I also authorize Cornerstone Pediatrics, PLLC to release any medical information acquired in the course of my child's examination or treatment, to any facility (including other physician, laboratory, hospital or ancillary providers) to which my child may need to be referred. I further authorize Cornerstone Pediatrics, PLLC to release any medical information determined in the course of my child's examination or treatment required to process medical claims, to my insurance carrier.

Parent /Legal Guardian Signature	Date
Provider for Cornerstone Pediatrics, PLLC	Date