Wright Pediatrics
18924 Freeport Dr. Ste B
Montgomery, TX 77356
936-582-7337

CONSENT TO SEEK MEDICAL TREATMENT OF MINOR

In the event you are unable to bring your child in we must have this form on file for any person(s) over the age of 18 seeking medical care for your child.

I, _____, give my permission for the following person(s) to bring my children in for medical attention at Wright Pediatrics:

_____ (Print first and last name)

_____ (Print first and last name)

_____ (Print first and last name)

_____ (Print first and last name)

Please allow the person(s) listed above to bring my child(ren), listed below, in to receive treatment by the Wright Pediatrics doctors and affiliates.

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

I can be reached at: (_____)_____-_____ with any questions or concerns.

_____
Signature of Parent/Guardian

HIPAA RELEASE OF INFORMATION MEDIA RELEASE AUTHORIZATION FORM

I,_____, hereby authorize Wright Pediatrics, it's duly authorized employees or agents, to publish:

- ☐ **Photographs of my child**
- ☐ **First name of my child**
- ☐ **Occasion:_____**

that may be used in print media, on our website, blog, and/or on the social media platforms such as Facebook, Instagram, Twitter, Pinterest, Tik Tok and YouTube.

I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by Federal and State privacy laws.

This authorization is valid from the date of my/my representative's signature below.

I understand that I have a right to revoke this authorization by providing written notice to this practice. However, this authorization may not be revoked if Wright Pediatrics, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or for coverage of services.

Name of patient:_____ Date of Birth:_____

Signature of Parent/Guardian:_____ Date:_____

Name of Parent/Guardian:_____