



**TLC Pediatrics of Frisco**

11700 Teel Pkwy Suite 200

Frisco TX 75033

214-618-6272; Fax 214-618-6277

I understand that as of my 18<sup>th</sup> birthday, I am considered an adult and therefore I need to give written consent to discuss my medication information with anyone other than myself, including my parents.

By signing this form I am designating the parties below with whom I wish TLC Pediatrics of Frisco to be able to discuss my medical information with. I understand that it is my responsibility to inform TLC Pediatrics of Frisco in writing of any changes pertaining to this release.

I \_\_\_\_\_ hereby authorize TLC Pediatrics of Frisco to discuss with and release my medical information to the individuals listed below. This release is written without restrictions and includes information relating to mental health.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date