Physician and Medical Information

All information will be kept confidential.

Hospital:

Clinic:

Physician

Physician's Name	Office Telephone	Fax	Email

Social Worker

Social Worker's Name	Office Telephone	Fax	Email

Child Life Specialist

Child Life Specialist's Name	Office Telephone	Fax	Email

Medical Release

All information will be kept confidential.

To grant your child's wish, we must contact his/her primary care physician to obtain information regarding his/her medical condition, which will enable us to serve your child to the best of our abilities. Please sign below to authorize your child's primary care physician to provide this information to **a Wish with Wings**. An "Authorization for Use/Disclosure of Protected Health Information" (HIPAA) form will be sent to you upon acceptance of said wish.

I/We authorize my/our child's primary care physician to provide **a Wish with Wings** the information necessary to grant my/our child's wish. I am the biological parent or legal guardian of _____ with the authority to execute this authorization permitting **a Wish with Wings** to obtain the information requested in this Wish Request Form. I/We further release, indemnify and hold harmless **a Wish with Wings**, its volunteers, officers, agents and employees from any damages, claims, causes of action, losses or liabilities arising out of the activities of **a Wish with Wings** with our family.

Both parents / legal guardians must sign below and have their signatures witnessed.

Parent / Legal Guardian's Signature	Witness' Signature
Parent / Legal Guardian's Signature	Witness' Signature

Signed this _____ day of _____ _____

Date Month Year

P 817-469-9474 | **F** 817-731-3399 | AWWW.org
3751 West Freeway, Fort Worth, TX 76107

aWishwithWings