WEST ALABAMA PEDIATRICS
DR. DAVID WALBURN

Following are the names & dates of birth of all children for whom I am the parent/guardian:

Name of Child Date of Birth

Name of Child Date of Birth

Name of Child Date of Birth

ASSIGNMENT OF BENEFITS

I, the undersigned, authorize payment of medical benefits to Dr. David Walburn M.D. for any services furnished to my child by the practice. I also authorize you to release to my child's insurance company or their agent, information concerning health care, advice, treatment or supplies provided to my child. This information will be used for the purpose of evaluation and administering claims of benefits. This assignment shall remain valid until I provide written notice removing this Assignment of Benefits.

Signature of Parent/Guardian if Patient is under 18 years of age Date

CONSENT FOR MEDICAL TREATMENT

I give authorization an consent for my child/children to be medically treated by Dr. David Walburn.

Signature of Parent/Guardian if Patient is uder 18 years of age Date