Information Release for patients 18 years of age and older

Patient's Information:

______________________________ _______________________

Patient's Name | Date of Birth

______________________________ _______________________

Home Address | Home Phone Number

____

City, State, Zip Code

The following person(s) have my permission to discuss my medical care with Pediatric Associates, Inc., including but not limited to making appointments, booking of diagnostic tests, and discussion with employees regarding medical conditions, symptoms, and/or treatment plans.

Please list any exceptions that you would NOT like discussed with any other person(s)

____

Name	Relationship

Patient's signature: ____

Date: ________________

This authorization will be in effect until changed by the patient.