Middleboro PEDIATRICS
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AUTHORIZATION FOR RELEASE OF INFORMATION TO PARENTS

FOR PATIENTS (check one) **____under age 18 ____age 18 and older**

PATIENT INFORMATION:

Patient Name:_____Date of Birth:_____

Address:_____

City:_____State:_____

Preferred Phone: Home_____Work _____Cell_____

RELEASE INFORMATION:
Middleboro Pediatrics may release all medical information, EXCEPT AS CHECKED BELOW, to the following individuals:

Mother's Full Name_____

Father's Full Name_____

Other_____

Information NOT TO BE released (check all that apply):

____Information about my use of birth control _____Information about sexually transmitted diseases _____Information about HIV and AIDS
____Information about pregnancy and/or abortion ___Information about drug or alcohol use or abuse _____Other

____OR I prefer that no information be released to anyone other than myself

I release Middleboro Pediatrics and its physicians and staff from all legal liability that may arise from the release of this information.

Signature of patient_____ Date_____