



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 TO:

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
(do not complete the "Release information to" portion when checking this)**

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 _____

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