MIDDLEBORO PEDIATRICS

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AUTHORIZATION FOR RELEASE OF INFORMATION TO PARENTS

PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____

Address:_____

Daytime phone #:_____ Evening phone #:_____

Check here if you prefer that no information be released to anyone other than yourself.

MIDDLEBORO PEDIATRICS MAY RELEASE ALL MEDICAL INFORMATION (EXCEPT AS LISTED BELOW) TO THE FOLLOWING INDIVIDUALS(Check all the apply):

____ Mother: Full Name_____

____ Father: Full Name_____

____ Other: Full Name_____

____ Other: Full Name_____

PLEASE DO NOT RELEASE THE FOLLOWING INFORMATION (Check all that apply):

___ Information about my use of birth control
___ Information about sexually transmitted diseases
___ Information about pregnancy and/or abortion
___ Information about drug or alcohol use or abuse
___ Information about HIV and AIDS
___ Other (please specify):_____
___ Other (please specify):_____

I release Middleboro Pediatrics, PC and its physicians and staff from all legal liability that may arise from the release of this information. I certify that I am 18 years of age or older.

_____

Date **Signature of patient**