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Release of Information Form Eighteen Years and Older

Due to HIPAA Regulations, we need to have accurate contact information to contact you. Please list the numbers where you can be reached:

_____ My cell phone number ( ) _____

_____ My work phone number ( ) _____

_____ Leave a message on voice mail or answering machine at home ( ) _____

Please list anyone by name that you would like **Pediatric Clinic, P. C.** to be able to discuss or release any of your medical information to:

_____ No one other than yourself

_____Mother, Father or other family member (must list names and phone numbers)

_____

_____

_____

I authorize any Associate of Pediatric Clinic, P.C. to discuss any of my protected health information, **including test results** with the above marked persons.

I authorize any Associate of Pediatric Clinic, P.C. to call, confirm or leave a voice recorded message at home, cell or with another family member as listed above.

I will provide a written notice when I choose to revoke or modify any of the above.

Printed Patient Name: _____ Patient Signature: _____

Date: _____ Signature of Witness: _____