BEACON PEDIATRICS

Authorization To Release Information

I, _____, am no longer a minor and I authorize Beacon Pediatrics to share medical information and results with my parent(s)/guardian.

As per Massachusetts and/or Federal Law, certain types of medical information are protected by law from release without specific consent, and will not be released as a result of this authorization.

If you **DO NOT** want these records released, please check the appropriate line(s) below:

_____HIV results
_____Mental Health records and references
_____Substance abuse (alcohol, narcotics, prescription drugs)
_____Communication with office psychologist
_____Sexually transmitted diseases
_____Termination of pregnancy
Or

_____Please release all medical information and results to my parent(s) or guardian.

My date of birth: _____
My cell phone #: _____

I will notify Beacon Pediatrics, in writing, when this document is no longer valid.

Parent(s)/Guardian name: _____

Signature of patient: _____Date:_____