AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby consent to and authorize the release of all pertinent medical information to or from **Hatboro Pediatrics, PC** as indicated below. In addition, I consent to and the release of medical information if the record contains any information regarding psychological treatment, alcohol treatment, and/or HIV-related treatment.

PATIENT NAME:____

PATIENT DATE OF BIRTH:______________________________________

THE ABOVE NAMED PATIENT IS MY (circle one)

SON **DAUGHTER** **SELF** **FOSTER CHILD** **OTHER:________________**

RELEASE OF MEDICAL INFORMATION

(circle one) **TO** **FROM**

NAME OF PERSON:____

ORGANIZATION:____

STREET ADDRESS:____

CITY, STATE, ZIP CODE:____

REASON FOR RELEASE OF INFORMATION:____

SIGNED (if not the patient, I also certify that I am parent/legal guardian of the patient):

______________________________ DATE:_______________ PHONE:_____________________