483 East County Line Rd.
Hatboro, PA 19040

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 Legal Name: _____

Patient Chosen Name: _____

Date of Birth: ____/____/_____

The Above Named Patient is My (check one)
❑ Self ❑ Child ❑ Foster Child ❑ Other: _____

Release of Medical Information
(check one) ❑ To ❑ From

Hatboro Pediatrics, PC

483 East County Line Road
Hatboro, PA 19040

Phone (215) 441-5670
Fax (215) 441-5661

Reason for Release of Information:_____

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

NAME: _____ DATE: ____/____/_____ PHONE: (_____)_____-_____