ABC PEDIATRIC GROUP

Authorization to Release Healthcare Information

Patient Name: _____ Date of birth: _____

A parent or legal guardian must accompany all patients under the age of 18. The parent or legal guardian can designate another person 18 or older to seek medical care for their minor(s) by completing the information below.

- I give consent to the following person(s) to accompany this patient to the visit, authorize treatment, and make healthcare decisions as necessary.
- I give consent for the following person(s) to receive my child's healthcare information
- I give consent for the following person(s) to receive prescriptions, medical records, and forms
- I understand that it is my responsibility to ensure that this authorization is updated as necessary.

Parent/Responsible party Name (print): _____ Date: _____

Parent/Responsible party Signature: _____

I consent and authorize the following people upon showing proper identification:

Name: _____ Phone_____ Relationship to patient _____

Name: _____ Phone_____ Relationship to patient _____

Name: _____ Phone_____ Relationship to patient _____

Name: _____ Phone_____ Relationship to patient _____

Name: _____ Phone_____ Relationship to patient _____

Additional Confidential Release of Information:

I authorize the release of STD results, HIV testing, whether negative or positive, to the person(s) listed above.

Yes, I give consent: Signature_____ Date_____

No, I do not give consent: Signature_____ Date_____

I authorize the release of any records regarding drugs, alcohol or mental health treatment to the persons listed above.

Yes, I give consent: Signature_____ Date_____

No, I do not give consent: Signature_____ Date_____