Record Number_____

Medical Information Form
18 and Over
The Pediatric Center

This form is to be filled out to give your parent/other access to your medical records.*(This is not a Medical Records Release)

NAME:_____ DOB ____/_____/_____
PHONE NUMBER:_____

RELEASE OF INFORMATION

( ) I authorize the communication and release of any medical records and billing information to:

( ) Parent_____
( ) Other_____
( ) This information is not to be released to anyone.

Signed: _____
Date_____/_____/_____