Age 18 Permission to Release Patient Information

Date: ____/____/____

PATIENT NAME: _____

DATE OF BIRTH: _____

I hereby authorize Abington Pediatric Associates to discuss information contained in my medical records with my parent/guardian(s)

_____
(Parent/Guardian(s) Name)

THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS THIS SECTION IS CHECKED OFF.

Psychiatric Records	___YES	___NO
Sexual Records	___YES	___NO
Drug & Alcohol Records	___YES	___NO

I understand that there may be medical records from another doctor or another medical facility in my chart.

This authorization is valid unless and until they are revoked, in writing, and presented to the Abington Pediatric Associates.

Signature of Patient: _____