CHILDREN & TEENS MEDICAL CENTER

2015 Authorization To Release Patient Information

Parent Name: ______________________________

Patient Name: ______________________________ Date of Birth: ____________

Patient Name: ______________________________ Date of Birth: ____________

Patient Name: ______________________________ Date of Birth: ____________

Patient Name: ______________________________ Date of Birth: ____________

I authorize Children & Teens Medical Center to discuss or release the following information:

Medical Information (labs, x-ray results, etc.) to: (*name & phone number*)

- ☐ Spouse: ______________________________
- ☐ Mother: ______________________________
- ☐ Father: ______________________________
- ☐ Other: ______________________________

Account Information (billing, appointments, etc.) to: (*name & phone number*)

- ☐ Spouse: ______________________________
- ☐ Mother: ______________________________
- ☐ Father: ______________________________
- ☐ Other: ______________________________

Pharmacy Name: ______________________________ Phone number: ____________

- ☐ I consent to have my prescription history obtained.

You can contact me ____________________ at: (*please indicate which number to call first*)

- ☐ Home # ____________________
- ☐ Cell # ____________________
- ☐ Work # ____________________
- ☐ E-mail ____________________
- ☐ You may leave a message on my voice mail and/or answering machine.
- ☐ DO NOT leave a message on/at ______________________________.

Parent Signature: ______________________________ Date: ______________

Any changes to the above information will need to be made in writing, and/or initialed and dated.