Wheaton Pediatrics
A helpful hand in your child's future.

CONSENT FOR RELEASE OF MEDICAL INFORMATION FOR PATIENTS 18 YEARS OF AGE AND OLDER

If you have questions regarding this form, please feel free to discuss with your provider

Patient Name: ____

Date of Birth: ______________________________

Patient Phone Number: ________________________

I hereby consent to the release of medical information to:
Mother, Father, legal guardian: (please list names and relationship)

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The medical information to include and be limited to:

_____ **Progress/Doctors Notes** _____ **Laboratory Data**
Initials Initials

Confidential Records (Please initial information that may be released)

_____ **Drug Screening/Testing**

_____ **HIV Screening**

_____ **Pregnancy Screening**

_____ **Sexually Transmitted Disease Screening**

_____ **Other: (Please specify)** ____
Initials

-OR-

_____ **Please do not release any medical information to anyone other than myself.**
Initials

______________________________________ ________________________
Patient Signature **Date**

______________________________________ ________________________
Guardian/Legal Representative Signature if required (Please specify relationship to patient) **Date**

***This consent expires one year from the date of signature.**

Updated 6.2013