

# Internal Medicine & Pediatric Associates

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## Release of Personal Health Information

*Please print clearly and complete the following information.*

**Patient Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

I authorize Internal Medicine & Pediatric Associates to release the following personal health information (please check the appropriate box).

- Lab Tests and Blood Work
- Imaging and Other Test Results
- Medication and Prescription Information
- Billing Information
- All Medical Records

The above personal health information may be released to the individual(s) listed below.

Name	Relationship	Date of Birth

I acknowledge and agree that I designated the above personal health information to be released to the individuals named above. I grant permission to Internal Medicine & Pediatric Associates to provide my designated personal health information to the individuals I named above. At any time upon request by an individual above, Internal Medicine & Pediatric Associates has my permission to provide my designated personal health information, verbally or in writing.

This permission is granted and remains in effect without time limit until I provide further written notice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Signature Date