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