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HACKENSACK PEDIATRICS
PEDIATRIC AND ADOLESCENT MEDICINE

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*** FOR PATIENT'S 18 YEARS AND OLDER ONLY ***

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FORM

I authorize any physician, medical provider, or other staff member of Hackensack Pediatrics to release to the following individuals any information regarding my medical history, symptoms, treatment, exam results, or diagnosis with the stated exceptions (if any):

_____ NO EXCEPTIONS

_____ Do NOT release any HIV or sexually transmitted disease laboratory results without prior consent

_____ Do NOT release any routine laboratory results without prior consent

_____ Exceptions as noted: _____

RELEASE INFORMATION TO:

_____ _____
1) Name Relationship to Patient

_____ _____
2) Name Relationship to Patient

_____ _____
3) Name Relationship to Patient

_____ _____
Patient's Name (must be 18 years or older) Date of Birth

_____ _____
Patient's Signature (must be 18 years or older) Patient's Cell Number

_____
Witness Name

_____ _____
Witness Signature Today's Date