Pediatric Associates of Plymouth

CONSENT/DISCLOSURE AUTHORIZATION FOR ADULT PATIENT(18 and over)

I, _____ (patient's name, print), DO ____ DO NOT ____

authorize Pediatric Associates of Plymouth to disclose medical information regarding myself to the following:

_____ _____
Name (print) Relationship

_____ _____
Name (print) Relationship

_____ _____
Name (print) Relationship

Specifically, _____ I am _____ I am not
authorizing this release to include information regarding mental health, drug or alcohol treatment, HIV or STD's.

This authorization: _____ Is effective from _____ to _____
(Date) (Date)

OR

_____ Is effective until revoked by me in writing

_____ _____
Signature of Adult Patient Adult Patient Cell Phone Number

_____
Date

Forms and Protocols/lgs/Aug 2018