Pediatric Associates OF PLYMOUTH

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Building a Healthier Future for Your Child

# CONSENT/DISCLOSURE AUTHORIZATION FOR ADULT PATIENT

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/April 2017