PEDIATRIC ASSOCIATES OF PLYMOUTH, INC.

PEDIATRIC AND ADOLESCENT MEDICINE

Jane Mooney Longacre, M.D., F.A.A.P.
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HOURS BY APPOINTMENT ONLY

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Disclosure Authorization for Adult Patient

I, ____________________________, authorize Pediatric Associates of Plymouth to disclose all medical
(name of patient)

information regarding myself to the following: ______________________ (name) ______________________ (relationship to patient)

______________________ (name) ______________________ (relationship to patient)

______________________ (name) ______________________ (relationship to patient)

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 ___________.

☐ is effective until revoked by me in writing.

____
(Signature of Adult Patient)

____
(Date)