Release Form for individuals involved in care of patient

I, _____, give Pediatrics Associates of Lewiston P.A. permission to speak with the following people regarding my child's health status, including diagnosis, treatment options and plans and payment for health services I receive from Pediatrics Associates of Lewiston P.A.

This consent is valid until such time as I provide Pediatrics Associates of Lewiston P.A. written revocation of it.

Patient Name:
DOB:

Pediatrics Associates of Lewiston, P.A. may speak with:

Name _____ DOB:_____
Address: _____
Phone:_____Relationship:_____

Name: _____ DOB:_____
Address:_____
Phone:_____Relationship:_____

Name: _____ DOB:_____
Address:_____
Phone:_____Relationship:_____

Patient/Guardian Signature: _____
Print Name:_____
Relationship to Patient:_____

Date: