BLOOMINGTON PEDIATRICS

Age 21 and Over Release of Information Form

PATIENT NAME: _____

PATIENT DOB: _____

I _____ give permission for Bloomington Pediatrics to release information to the following persons:

NAME	**RELATIONSHIP**	**PHONE NUMBER**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
Signature of patient	Patient Ph. Number	Date