BLOOMINGTON PEDIATRICS

Age 18-20 Release of Information Form

PATIENT NAME: _____

PATIENT DOB: _____

PATIENT EMAIL FOR PORTAL (required for access as of age 18):

_____

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

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

This consent will expire when the patient reaches 21 years of age. A new form must be completed by the patient at that time.

_____	_____	_____
Signature of patient	Patient Ph. Number	Date