BLOOMINGTON PEDIATRICS

Age 21 and Over Release of Information Form

PATIENT NAME: ___________________________________

PATIENT DOB: _____________

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

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

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

______________________	______________________	______________________
Signature of patient	Patient Ph. Number	Date