BLOOMINGTON PEDIATRICS

Age 18 and Older 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 on (*enter date*) _____ or upon written notice from the patient.

_____	_____	_____
Signature of patient	Patient Ph. Number	Date