BLOOMINGTON PEDIATRICS

Age 17 and Under 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This consent will expire when the patient reaches 18 years of age. A new form must be completed by the patient at that time.

_____	_____	_____
Signature of parent	Parent Ph. Number	Date