BLOOMINGTON PEDIATRICS & ALLERGY

Age 18-20 Release of Information Form

PATIENT NAME: ________________________________

I ____________________________________ give permission for Bloomington Pediatrics & Allergy 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