BLOOMINGTON PEDIATRICS & ALLERGY

Age 21 and Over Release of Information Form

PATIENT NAME: ___________________________________

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

NAME	RELATIONSHIP	PHONE NUMBER
_____________________________	___________________	_______________
_____________________________	___________________	_______________
_____________________________	___________________	_______________
_____________________________	___________________	_______________

_____________________________	___________________	_______________
Signature of patient	Patient Ph. Number	Date