

**NORTHEAST PEDIATRIC ASSOC., P.C.**  
**PERMISSION TO RELEASE MEDICAL INFORMATION**  
**18 YEARS & OLDER**

Name: \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_

**PLEASE CIRCLE ONE OF THE FOLLOWING:**

My medical information can be released to:

Release my medical information to my parents.

Release my medical information only to my mother.

Release my medical information only to my father.

Release my medical information to: \_\_\_\_\_

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Signature of patient (18 years of age & older)

Date

According to HIPPA Privacy Regulations, Northeast Pediatrics cannot disclose protected health information unless permitted by the regulation and procedures designed to protect this information. If the patient is 18 years of age or older, the patient must sign a written release in his/her chart before any information can be released for the intended purpose or what has been specified on a HIPPA authorization.

Patient Release-18 yrs

August 2020