**CENTRE PEDIATRIC ASSOCIATES, P.C**

## Authorization for Release of Protected or Privileged Information to Parent or Guardian of Patient 18 Years or Older

Patient Name:_____Patient Date of Birth:_____

Address:_____

I, the above named patient, do hereby authorize Centre Pediatric Associates, PC to release my health form information and to allow the following parent(s) or guardian(s) to speak with triage on my behalf.

Parent/Guardian Name: _____

Parent/Guardian Name: _____

I understand that I may withdraw my authorization at any time by submitting a written request to the Practice Administrator at Centre Pediatric Associates, PC.

I understand that this authorization will automatically expire: (please check one):
[ ] in 3 months
[ ] in six months
[ ] 1 year from this date
[ ] Upon a specific event (specify event) _____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records, of my condition to those persons listed above.

Signature of Patient 18 Years or Older:

_____Date: _____

Signature of Witness: _____