



LOWER BUCKS PEDIATRICS, PC

**1690 Big Oak Road
Yardley, PA 19067**

**Telephone (215) 493-1750
Fax (215) 493-1470**

Web: www.lowerbuckspediatrics.com
Email: info@lowerbuckspediatrics.com

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby consent to and authorize the release of all pertinent medical information to or from Lower Bucks Pediatrics, P.C. as indicated below. In addition, I consent to and the release of medical information if the record contains any information regarding psychological treatment, drug treatment, alcohol treatment, and/or HIV related treatment.

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

THE ABOVE NAMED PATIENT IS MY (circle one):

SON DAUGHTER SELF FOSTER CHILD OTHER: _____

RELEASE THE MEDICAL INFORMATION

(circle one:) **TO** **FROM**

NAME OF PERSON: _____

ORGANIZATION: _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

REASON FOR RELEASE OF INFORMATION: _____

SIGNED (if not the patient, I also certify that I am parent/legal guardian of the patient):

_____ DATE: _____ PHONE #: _____