South County Pediatric Associates
Consent to Release Medical Information

Patient's Information:

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Name Date of Birth

____

Address City, State, Zip

☐ I authorize South County Pediatric Associates to discuss any of my medically privileged information with:

____

Name Relationship

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Name Relationship

☐ I DO NOT authorize South County Pediatric Associates to speak with anyone other than myself concerning any medically privileged information.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
You have a right to receive a copy of this authorization.

You have a right to withdraw this authorization at any time by providing a written statement of withdrawal to South County Pediatric Associates. Your withdrawal will not be effective until received by South County Pediatric Associates and will not be effective regarding the uses and or disclosure of your health information that South County Pediatric Associates has made prior to receipt of the written withdrawal statement.

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Signature

____

Date