



Orchard Pediatrics, P.C.

Newborn through Adolescent Care

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PATIENT 18 YR & OLDER RELEASE FORM

Patient name: _____

Date of Birth: _____

I authorize Orchard Pediatrics to release my medical information to the following persons:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

Topics I would not like discussed with my parents:

PATIENT SIGNATURE DATE CELL PHONE #

WITNESS SIGNATURE DATE

PHYSICIAN SIGNATURE DATE