Dearborn Pediatrics

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PERSONAL HEALTH INFORMATION RELEASE FORM

By signing this form, I authorize Dearborn Pediatrics to allow the following person (s) to:

- ❑ Request prescription refills
- ❑ Obtain test results
- ❑ Make appointments
- ❑ Speak to Providers regarding clinical findings
- ❑ Other

Patient Information

Patient Name
Patient DOB
Patient Address
Patient Phone #
Patient Email

Receiver's Information

Receiver's Name
Receiver's Relationship to Patient
Receiver's Phone #
Receiver's Email

Authorization Period

This authorization for release or information covers the period of healthcare from

________________________________ to ________________________________

If left blank this form will expire in one year from date signed.

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SIGNATURE

Disclaimers

You may revoke this authorization at any time. Please send written notification of the revocation to Dearborn Pediatrics. Your notice will not apply to actions taken by parties prior to your revocation date.