FAIRVIEW PEDIATRICS, LLC

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Adult Patient Release of Information Form

Date: _____

Patient Name: _____ **Date of Birth:** _____

Please choose one of the following two options:

☐ 1. **I do not give permission** for Fairview Pediatrics to speak to anyone other than myself regarding my healthcare.

*I understand that, if I do not give permission for Fairview Pediatrics to speak to any person besides myself regarding my healthcare, that I am taking full responsibility for my medical care, appointments, and financial arrangements or insurance issues. Also, I understand that if I decide to change or revoke this, I will need to do so in writing.

☐ 2. **I give permission** to Fairview Pediatrics to speak with:

_____ _____

(Print Name) (Relationship to patient)

Please check each additional condition/situation for which the above-named person may speak with your physician or the staff at Fairview Pediatrics.

- ☐ Medical Conditions/Appointments
- ☐ Drug and Alcohol History
- ☐ HIV History
- ☐ Sexual History
- ☐ Psychiatric History
- ☐ Miscellaneous Test Results/Labs/X-rays

This permission with expire upon my termination as a patient at Fairview Pediatrics.

Patient Signature: _____