



Authorization for Release of Confidential Medical Information of Minors

Authorization to Release medical information with no restrictions

I, _____, as guardian of _____
Print name Name of patient under 18 years old

DOB _____ authorize the staff of Name of Office Location to release information regarding his/her most recent test results and/or office appointment issues to me and/or: (Check off)

- Leave message on my home voice mail
- Speak to/Name: _____ Relation: _____
Needs to be over 18 years old

Date: _____ Guardian Signature: _____

Refusal to allow release of medical information

I, _____, as guardian of _____
Print Name Name of patient under 18 years old

DOB _____ **do not** authorize the staff of Name of Office Location to release information regarding his/her most recent test and/or office appointment issues to **anyone** other than myself.

Date: _____ Guardian Signature: _____