‘

RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: ____

BY SIGNING BELOW, I AUTHORIZE **Chapin Pediatrics, PA** TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
GRANDPARENTS	☐ YES	☐ NO	______________________________
SIBLINGS	☐ YES	☐ NO	______________________________
IN-LAWS	☐ YES	☐ NO	______________________________
CAREGIVERS	☐ YES	☐ NO	______________________________
PARENTS	☐ YES	☐ NO	______________________________

OTHERS ______________________________

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE ______________________________

DATE __________________

We ask that if you have any change in this request, that you please inform the receptionist.

CHAPIN PEDIATRICS MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP			
GRANDPARENT	☐ YES	☐ NO	______________________________
RELATIVE	☐ YES	☐ NO	______________________________
CAREGIVER	☐ YES	☐ NO	______________________________

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE ______________________________

DATE __________________

I UNDERSTAND THAT **CHAPIN PEDIATRICS** WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.