



## 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
SIBLINGS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
IN-LAWS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WORK	<input type="checkbox"/> YES	<input type="checkbox"/> NO
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE \_\_\_\_\_

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

RELATIONSHIP			
GRANDPARENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVER	<input type="checkbox"/> YES	<input type="checkbox"/> 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.