



# English Road Pediatrics & Adolescent Medicine, LLC

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## CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize English Road Pediatrics to release the following medical information:

- |   |   |
|---|---|
| <input type="checkbox"/> Vaccination Record | <input type="checkbox"/> School Health Form     |
| <input type="checkbox"/> Daycare Form       | <input type="checkbox"/> Sports Evaluation Form |
| <input type="checkbox"/> WIC Form           | <input type="checkbox"/> Other: _____           |

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Parent/Guardian Information:

\_\_\_\_\_ Name

\_\_\_\_\_ Street Address

\_\_\_\_\_ City State Zip Code

\_\_\_\_\_ Home Phone Cell # Fax

Authorized by:

\_\_\_\_\_ Parent/Guardian signature

\_\_\_\_\_ Date