



## CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_ herby authorize  
(Print client's first, middle, last name)

Senders Pediatrics to release the following information, concerning me, to:

\_\_\_\_\_  
(Name of person) (Relationship) (Phone)

Items and Information to be released are:

- |  |   |
|--|---|
| <input type="checkbox"/> Progress Notes                | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Laboratory Results            | <input type="checkbox"/> Medication Records   |
| <input type="checkbox"/> Emergency-related Information | <input type="checkbox"/> Allergy Records      |
| <input type="checkbox"/> Medical Correspondence        |   |
| <input type="checkbox"/> Other _____                   |   |

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I may revoke this consent at any time by giving written notice, except to the extent that action has been taken in reliance on it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Cell phone number: \_\_\_\_\_

\_\_\_\_\_**I hereby revoke the above authorization to release confidential information.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_