18+ Patient Authorization

This authorization is for patients 18 years of age and older

Patient Name:_____ **Date of Birth:** _____

By signing this release, I give the following person(s) permission to discuss my medical care with Pediatric Associates, Inc., including but not limited to making appointments, booking of diagnostic tests and discussions with employees regarding medical conditions, symptoms and/or treatment plans.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient Date

This authorization will be in effect until changed by the <u>Patient</u>