Springville
Pediatrics

Release of Medical Information to Family and Others

Patient Name ____________________________________ *Date of Birth* _____/_____/_____

I authorize Springville Pediatrics to release my medical information as specified below to

____.

❑ *Any medical information, now and in the future.*

❑ *Specific medical information* ____

Expiration Date _____/_____/_____

Patient Signature ____ *Date* _____/_____/_____

Witness ____ *Date* _____/_____/_____

Note: Certain information is considered to be sensitive in nature and as required by law may not be released to anyone except the patient!