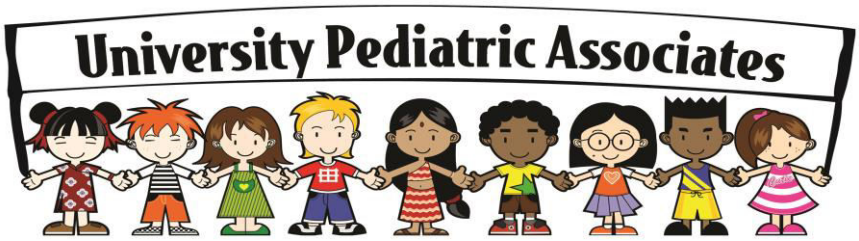

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AUTHORIZATION TO RELEASE/NOT RELEASE MEDICAL INFORMATION FOR PATIENTS 18 YRS OLD OR OLDER

Patients Name: _____
(Print): Last name/First name

Phone Number: ( ) _____

To Release:

I, _____ (print name), give permission to University Pediatric Associates, staff to discuss any medical conditions with my Parent(s)/Guardian(s).

This includes providing them with any copies of my medical records as requested by them.

This authorization will remain in effect until I choose to retract it.

Signature_____ DATE: _____/_____/_____

To Not Release

I, _____ (**print name**), decline giving permission to University Pediatric Associates staff to discuss any medical conditions with my Parent(s)/Guardian(s).

This includes providing them with any copies of my medical records as requested by them

This authorization will remain in effect until I choose to retract it.

Signature_____ DATE: _____/_____/_____