



Pediatric Healthcare

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Over 18 Years of Age Authorization to Release Information

This is to state that I, _____

am over 18 years of age and I authorize Pediatric Healthcare, PC to release any

and all of my medical information to _____

_____.

By signing this form I agree to allow Pediatric HealthCare to communicate with my parents regarding insurance and billing issues.

I may rescind this authorization in writing at any time in the future.

Signature Date

Printed Name