Park Avenue ENT

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO PARENTS OR GUARDIANS

Patient Name: _____

Patient Date of Birth: _____

I authorize **Jacqueline E. Jones, MD** to release my medical information solely to my parents or guardians:

Parents or Guardians Name: _____

Address: _____

Phone Number: _____

This authorization is valid until revoked.

I understand that the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I further understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy regulations. If I have questions about disclosures of health care, I may contact Dr. Jacqueline Jones or the Practice Administrator.

I have the right to revoke this authorization in writing at any time.

_____ _____

Patient Signature Date