NORTHERN LIGHTS PEDIATRIC & ADOLESCENT MEDICINE

Consent Form to Verbally Release Health Information

- *Patients who are 18 years or older and Emancipated Minors*
- *Minors receiving treatment for mental health issues, chemical dependency, family planning or sexually transmitted disease.*

Expiration of this Consent – this consent will end one (1) year from the date the form was signed unless you indicate an earlier date or event here.

Patient Information:

First Name: _____ Last Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: ____ Zip: _____
Your Cell/Daytime Phone: _____ Your Email Address: _____

Contact Information – Who we can talk to?

I give permission for Northern Lights Pediatrics to talk to the following people:

1. First Name: _____ Last Name: _____ about the information indicated below.
   The person can be reached at: Daytime Phone: _____ Evening Phone: _____
   Relationship to you, the Patient: _____

2. First Name: _____ Last Name: _____ about the information indicated below.
   The person can be reached at: Daytime Phone: _____ Evening Phone: _____
   Relationship to you, the Patient: _____

Indicate the information that you are authorizing us to verbally discuss with the people listed above.

CHECK (√s) all that apply.

____ Specific dates/years of treatment _____
____ All health information **OR**

____ Medications	____ Chemical dependency or alcohol related care
____ Immunizations	____ Birth control, family planning, or pregnancy
____ Health/Behavioral Care	____ Sexually transmitted disease (STD) care
____ Billing records	____ Laboratory results

____ Other information or instructions _____
_____

Authorization:

Patient's Signature: _____ **Date:** _____

Continued Authorization: Initials: _____ Date: _____ Initials: _____ Date: _____