

BLOOMINGTON PEDIATRICS & ALLERGY
Under 18 Release of Information Form

PATIENT NAME: _____

I _____ give
permission for Bloomington Pediatrics & Allergy to
release information to the following persons:

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This consent will expire when the patient reaches 18
years of age. A new form must be completed by the
patient at that time.

Signature of parent Parent Ph. Number Date