Angier Pediatrics and Adult Medical Center, PLLC
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CONSENT FORM TO RELEASE MEDICAL INFORMATION

Printed Name of Patient: _____ **Date of Birth:** _____

I give consent and authorize **Angier Pediatrics and Adult Medical Center, PLLC to** release information regarding my medical history to the following individual(s):

_____	_____
PRINTED NAME	**RELATIONSHIP**
_____	_____
PRINTED NAME	**RELATIONSHIP**

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Representatives Relationship To Patient and Phone Number Date

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ **BY:** _____