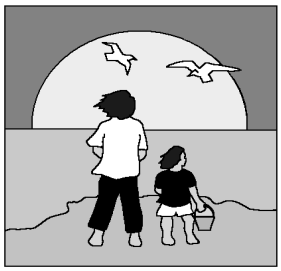

North Shore Pediatrics

www.northshorepeds.com
480 Maple Street, Suite 3A, Danvers, MA 01923
978-406-4234 Fax 978-921-2968

Authorization of Release of Information to Family Members/Guardians

Date_____

I, _____ give permission to _____ to have access to my protected health information in the following manner:

_____Scheduling/ changing appointments

_____Talking to triage nurse regarding myself (or my child) _____

_____Access to **ALL** my medical records including labs, office visits, and discussions with my doctor, etc

_____I DO NOT give my parents/guardians permission to any of my medical records

Signature: _____