



# North Shore Pediatrics

*www.northshorepediatrics.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: \_\_\_\_\_