North Park Pediatrics, LLC
403 North Avenue, Suite 4C
Bel Air, MD 21014
410-879-5170

Consent for Release of Confidential Information

I, _______________________________, authorize North Park Pediatrics, LLC to discuss information relevant to my child's healthcare with the following professional:

Name of Professional: ____

I understand that my child's records are protected as confidential under federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with federal law and regulations. I also understand that I may revoke this consent at any time and will expire one year after the date signed unless otherwise specified here.

Child's Name: ____DOB: ____/____/____

Parent / Guardian Name (printed): _____________________________ Date: ____/____/____

Parent / Guardian Signature: ____________________________________