River's Edge
PEDIATRICS

John P. Sotos, M.D. • Omolara Y. Dairo, M.D. • Michele V. Mahoney, M.D.

I, _____ give consent for
(Print Name and Date of Birth)
River's Edge Pediatrics, Inc. to release any medical information (Protected Health Information – PHI) to, _____.
(Name(s) and Date(s) of Birth)

This consent shall be in force and effective until: _____

I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to the Privacy Officer at River's Edge Pediatrics, Inc.

_____ _____
Witness Patient's Signature

_____ _____
Date Date

This form is intended for patients over the age of 18 who are giving their consent for their parents to still receive medical information (Protected Health Information – PHI.

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