



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).