



Pediatric & Adult Medicine, Inc.

A Member of CHOC Children's Network

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Date: _____

MRN: _____

Please initial your decision choice.

_____ I **DO** give authorization for the physicians and staff of Pediatric & Adult Medicine, Inc. to speak with Any contact, Additional Contact, Emergency Contact Next of Kin.

_____ I **DO NOT** give authorization for the physicians and staff of Pediatric & Adult Medicine, Inc. to speak with Any contact, Additional Contact, Emergency Contact Next of Kin.

This authorization does not include information regarding sexual relations, sexual abuse, sexually transmitted diseases, etc., pregnancy, drugs, alcohol use, suicidal thoughts / mental health issues, violence or abuse of any kind.

This authorization is in effect until an updated form is submitted by me.

Signature

Date of Birth

Printed Name

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