

Internal Medicine & Pediatric Associates
Personal Information Release Form
Drs. Karem, Kayrouz, Kelley, Ragland

Date Permission Given: _____

Patient Name: _____ SS# _____

I hereby authorize IMPA to give the following information regarding: (please check)

- Lab Tests/Blood work
- X -ray results
- Test Results (of any nature)
- Any and all medical record information

to the below listed individuals:

(1) _____
Name SS#

Relationship to patient:

(2) _____
Name SS#

Relationship to patient:

(3) _____
Name SS#

Relationship to patient:

As the above named patient I do hereby acknowledge and agree to the above disclosure of personal medical information at any time it may be required to requested by the above named individuals.

***** Unless written changes are made by the patient this information will remain in effect without a time limit.

Patient Signature (Parent Signature) Date