tamalpais pediatrics

Julie M. Bokser, MD
Nelson Branco, MD
John M. Harvey, MD
Erin N. Heath, MD

John S. Lee, MD
Jan E. Maisel, MD, PhD
Stephen A. Santucci, MD
Jeanette White, MD, PhD

Brenda Evans, PNP
Margo Hanlan, PNP
Sara Koenig, PNP

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Age 18 Consent to Release Patient Information

Date: ____/____/____

I, ____ hereby authorize

Tamalpais Pediatrics to discuss the following information contained in my medical records with

my parent/guardian(s) ____.
(Parent/Guardian(s) Name)

- ☐ Well Child Care Exam
- ☐ Blood Work Results
- ☐ Sick Visits
- ☐ Treatment/Medication

If there are any subjects you would **NOT** like to have discussed, please list them below:

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My preferred confidential contact information is:

Phone: _______________________________ Email:__________________________________

Signature of Patient: ____

5 Bon Air Road, Suite 105 | Larkspur, CA 94939 | (415) 461-0440 ph | (415) 461-3792 fax
400 Professional Center Drive, Suite 423 | Novato, CA 94947 | (415) 892-0965 ph | (415) 461-3792 fax