10 Queen Street
Newtown CT, 06470
Phone: (203) 426-3267
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Laura Nowacki, MD
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CONSENT TO DISCUSS MEDICAL INFORMATION AND PROTECTED HEALTH INFORMATION OF A PATIENT OVER 18 YEARS OF AGE

Name:_____________________________________ **DOB:**_______________________

I certify that I am 18 years of age or older and I authorize Newtown Center Pediatrics to share all of my protected health information with the following individuals.

____
Parent/Legal Guardian **Phone #** **Relationship**

____
Parent/Legal Guardian **Phone #** **Relationship**

I further request the following information be my primary contact information:

Phone:____________________________ **Email:**_____________________________

Address: ____

This authorization will remain in effect until I am no longer a patient of Newtown Center Pediatrics **OR** until the following defined date:________________________________.

I understand that I may revoke this authorization at any time for any reason by contacting the office.

____ ______________________
Patient Signature **Date**