Mary Braithwaite, MD
George Stablein,MD
Christopher Morton,
Jennifer Singleton, MD
Scott Woodrum, MD
Mary Cooley, MD
Charles Johnson, MD
Shruti Nagaraj, MD
Walker Robinson, MD
Andrea, Dunk, MD
Kathy Merritt, MD
M.Lynn Silkstone,MD
Christiana Akwari, MD

Consent to Discuss and/or Release Medical/Psychological/School Information

_____ _____

(Patient Name) **(Birth Date)**

_____ _____

(Address) **(Home Phone)**

_____ _____

(City, State, Zip) **(Cell Phone)**

I, _____, do hereby authorize _____

(Parent/Child over 12 years)

Chapel Hill Pediatrics and Adolescents, P.A. to discuss and/or release all medical/psychological/school records pertaining to the care and treatment regarding discussion/transfer of written records, school problems, psychiatric care and/or psychological assessment, and treatment of the previously stated between Dr._____ and _____

_____.

_____ _____

(Patient Signature if over 12 years) **(Date)**

_____ _____

(Signature of Parent or Legal Guardian) **(Date)**

Chapel Hill Pediatrics and Adolescents, P.A.
205 Sage Rd., Suite 100 East NC HWY 54, Suite 230
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