



## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To any physician, medical facility, psychiatrist, psychologist, adoption agency, federal, state, county or city agency, attorney or lay person.

You are authorized to release to:

**Family to Family Adoptions, Inc.**

Any and all medical, health information, psychological, psychiatric, birth certificate, or miscellaneous records pertaining to me or any child of mine who is being considered for adoption. You are further authorized to freely verbally discuss any interaction you may have had or may have with me in relation to this adoption or my past history.

You have my authorization to copy or receive copies of any and all records or documents pertaining to me of the information specified above.

This information may be used in connection with any proceeding concerning the adoption, guardianship, custody, and control of the child (born or unborn) being considered for adoption.

Birth date or expected due date of said child or children is: \_\_\_\_\_.

In the event of a placement of my child for adoption, I, the undersigned, being the parent of this child, authorize and empower the adoptive parents or agency to whom I release the child to make any decisions or provisions concerning medical and surgical care for said child, including anesthesia, which may be deemed necessary or advisable by any licensed physician during the period following the filing of a petition for adoption with the court, and throughout the pending adoption process.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Phone Number

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Fax #