

Riverside Pediatrics, Inc.  
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### MEDICAL INFORMATION RELEASE FORM

I hereby consent to authorize the release of medical information on my child;

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To: Riverside Pediatrics, 50 Amaral Street, East Providence, RI 02915

Select your provider:

Jill Gabrielsen, M.D.       Joseph Singer, M.D.       Patricia Lynch-Gadaleta,  
PA-C

Signature of Parent/Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_