Patient Name: ____
Last *First* *Maiden* *Middle*

Social Security Number:______-______-______ Date of Birth:______/______/______ Age:______________

ADULT

You may release my medical information to: (Not for Medical Records release of info)

______________________ ______________________ ______________________
Name and relation *Name and relation* *Name and relation*

______________________ ______________________
Signature of Patient / Legal Guardian *Date*

PEDIATRIC

I, ______________________________, biological parent / legal guardian of ______________________

(D.O.B. ______________) hereby give my permission to examine, treat, etc. the above child without my being present. This permission is only intended to facilitate my child's healthcare if I am unable to be with my child. I give this permission to the following to bring my child to appointments and leave a message about my child:

______________________ ______________________
Name Relation

______________________ ______________________
Name Relation

______________________ ______________________
Name Relation

I also understand that adolescents have certain legal rights of confidentiality, legally, and that I should get his/her permission to get information from the physicians.

______________________ ______________________
Signature of Parent / Legal Guardian Date

______________________ ______________________
Witness Date

Care Permission Form

Ambulatory Services

Form #: M11 Rev. 10/8/12