VOLUSIA MEDICAL CENTER

RELEASE OF INFORMATION

PATIENT NAME: _____

I, _____,hereby give my consent to speak with the following people in regards to my child or my own medical information. The following individuals also have my permission to escort my child/dependent to the physician office and consent to any necessary medical procedures in my absence. He/She may pick up prescriptions, lab results and medications on my behalf.

NAME: _____ (RELATION TO PATIENT)_____

NAME: _____ (RELATION TO PATIENT)_____

NAME: _____ (RELATION TO PATIENT)_____

PARENT/GUARDIAN INFORMATION

MOTHER'S NAME: _____ PHONE:_____

FATHER'S NAME:_____ PHONE:_____

GUARDIAN:_____ PHONE:_____

POWER OF ATTORNEY:_____ PHONE:_____

_____ _____

Signature Date