Consent Form to Release Information

Please fill out the following form if you would like to have documents or prescriptions picked up by a family member.

I,

Full Name: _____

Date of Birth: _____

Signature: _____

Provide the following individual,

Name: _____

Date of Birth: _____

The authorization and permission to pick up the following: (check one)

_____ Prescription Medication and/or medical devices

_____ Documentation (Please specify: _____)

_____ Medical advice or information related to my health.