PERMISSION FOR MEDICAL TREATMENT AND RELEASE OF MEDICAL RECORD INFORMATION

TO: Montgomery Regional Hospital
Your Hospital of Choice

3700 South Main Street
Blacksburg, VA 24060
(540) 951-1111

I/we, the parent(s)/legal guardian(s) of the child listed below hereby authorize permission for medical treatment of and release of medical record information concerning our child in the event we cannot be reached (please type or print):

Child's Name ______________________________

Home Address ______________________________ Home Phone ______________

Date of Birth ______________________________

Allergies ______________________________

Date of last tetanus/diptheria booster ______________________________

Routine or current medications ______________________________

Significant medical problems ______________________________

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Family physician or pediatrician's name ______________________________

Father's Name ______________________________ Home Phone ______________

Where employed ______________________________ Bus. Phone ______________

Mother's Name ______________________________ Home Phone ______________

Where employed ______________________________ Bus. Phone ______________

Authorization Date ______________ Authorization shall remain in effect until ______________

Parent/guardian signature ______________________________

Parent/guardian signature ______________________________

By typing or drawing my/our signature(s) above, I/we acknowledge that it is my/our intent to electronically sign this document and agree to the use of electronic records for the purposes provided herein.

Permission forms should be filled out for each child and left with the person caring for the child. Additional copies of the form are available from the hospital's Public Relations office or Emergency Department.