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 _____

_____

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 _____

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.