STEPHEN J. CLARK M.D.
CHRISTINE F. KHARASCH M.D.

3021 FALLING WATERS BLVD. S-A
LINDENHURST, IL. 60046

AUTHORIZATION RELEASE

DATE:____________________

PATIENT NAME:________________________________ DOB:_____________________

If Minor: Father Name ___________________________ Mother Name _________________________

I hereby authorize _________________________________ or _________________________________

to bring my child/minor _________________________________ to seek medical treatment, if I am unavailable to personally be present. This authorization shall stay in effect until I personally revoke or request it be removed from the file.

____
Parent/Guardian

AUTHORIZATION PICK UP MEDICATION/PRESCRIPTIONS/MEDICAL INFORMATION

DATE: __________________________

PATIENT NAME: ____ DOB: ____________________

I hereby authorize _______________________________ or __________________________________

to pick up samples of medication, prescriptions, or medical information. This authorization shall stay in effect 12 months from the date signed or until I, personally revoke or request it be removed from the file.

____
Patient/Parent/Guardian

NOTE: This is not a signed authorization for our office to release medical records. See other form.

THIS FORM WILL EXPIRE 1 YEAR FROM TODAY'S DATE. NEW FORMS WILL NEED TO BE COMPLETED.