STEPHEN J. CLARK 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.