PATIENT (18 YRS AND OLDER) PERMISSION CONSENT FORM

Date: _____

I, _____, _____
(NAME) (DATE OF BIRTH)

give permission for those listed below to pick up prescriptions and receive medical information concerning myself. The individuals listed below will have to show proper identification.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

I, _____, _____
(NAME) (DATE OF BIRTH)

DO NOT give permission for anyone other than myself to receive information regarding my healthcare or access to my chart, or pick up prescriptions.

- **If any of the above information changes it will be the responsibility of the patient named above to contact our office at 985-868-5440.**

_____
Patient Signature