

Pisgah Family Health, P.A.
Medical Release for Minor Child

Please PRINT

I, _____,
(Parent or Legal guardian of)

_____,
(name of minor child),

hereby authorize any Medical or Surgical treatment which may be necessary in an urgent illness or emergency situation, and in my absence, for the well being of the above mentioned minor.

I agree to hold Gary Curran, MD of Pisgah Family Health treating the above mentioned minor, harmless.

Parent or Legal guardian name: _____

Address: _____

City, State, Zip: _____

Home ph #: _____ Work ph #: _____ Cell ph #: _____

I authorize the following family member(s) to bring my minor child for treatment:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Parent or Legal guardian signature

Date _____