Permission to Obtain Medical Information / Pick up Prescriptions

I, _____, date of birth _____, authorize
Patient Name

the following individuals to have access to my medical information and records:

Name: _____

Name: _____

Relation: _____

*Patient Signature: _____ Date: _____

I give permission for the following individual to pick up prescriptions written under my name as a patient of Bee Caves Pediatrics:

Name: _____

Name: _____

Relation: _____

*Patient Signature: ________________________________ Date: _________________