Pediatric Gastroenterology of Charleston

Authorization Release &

Emergency Contact Form

Parent/Legal Guardian name: _____

Home address: _____

Mailing address (if different) :_____

Phone #'s Home: ( ) _____

Cell: ( ) _____

Work: ( ) _____

Other: ( ) _____

Child's Name (Patients only)	**Date of Birth (Patients only)**	**Social Security # (Patients only)**

I, _____, give permission to release any medical record, lab or test result, to the person/person's named below, in the event that I am not reachable.

In case of emergency please contact:_____

Relationship to patient:_____

Phone Numbers: ( )_____, ( )_____, ( )_____

Signature:_____

428 Division Street, Suite #3A, S. Charleston, WV 25309 Phone: (304) 400-4626, Fax: (304)400-4634