DOCTORS INLET PEDIATRICS & PRIMARY CARE, P.A.
d/b/a Avenues Pediatrics & Avenues Internal Medicine

430 College Drive, Suite 100-102-104
Middleburg, FL 32068-8531

10175 Fortune Parkway, Suite 401
Jacksonville, FL 32256-6746

ADULT CONSENT FOR RELEASE OF MEDICAL INFORMATION/TREATMENT AND PHARMACY INFORMATION

I, _____, hereby authorize any one of the following individuals to obtain any or all of my medical information as deemed necessary and appropriate for treatment by a physician licensed in the state of Florida. This consent includes, but is not limited to, medical information and treatment.

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

I further agree to reimburse the health care provider for the cost of rendering these services. This authorization is good until it is withdrawn..

_____ DATE _____
Signature of Patient

PHARMACY INFORMATION
Pharmacy Name: _____ Phone #: _____
Address: _____
City: _____ Zip: _____

PLEASE NOTE THIS PHARMACY WILL BE USED FOR ALL PRESCRIPTIONS. PLEASE NOTIFY US OF ANY CHANGES IMMEDIATELY.

OFFICE STAFF:
Driver's License OR Photo Identification checked and scanned into system

_____
Initials

Address on Driver's License matches information on form

_____
Initials