

Smith House Family Health Care Center
39 Farrell Road, Willsboro, NY 12996
Telephone (518) 963-4275, Fax (518) 963-8862

Pok-O-MacCready Camper
Patient Statement of Release

Patient				
Name (last, first, middle)	SS#	Age	Sex	DOB
Street Address	City, State, Country, Zip			
	Phone			

Responsible Party				
Name (last, first, middle)	SS#	Age	Sex	DOB
Street Address	City, State, Country, Zip			
	Work Phone			
Relationship to Camper	Home Phone			

Emergency Contact Information		
1. Name	Relationship	Phone Number
2. Name	Relationship	Phone Number

Primary Care Provider	
Name	Phone Number
Address	

Please list any additional contact or medical information

Statement of Release: I verify that I have provided Camp Pok-O-MacCready with authorization to select medical personnel and facilities necessary for the treatment or emergency care of my child and that I have fully completed and submitted a Health History and Exam Form to the camp. Furthermore, by signing this **Patient Statement of Release** (below), I now authorize Smith House Family Health Care Center to review and copy for their medical records any and all information contained on the Health History and Exam Form should my child be presented to the Smith House for care and treatment. I also understand that by signing this **Patient Statement of Release**, I am authorizing the Primary Care Physician named above to release to the Smith House Family Health Care Center confidential medical information including medical records, x-ray films & reports and other information determined necessary for the care and treatment of my child. This authorization will automatically expire 4 months from the date below.

 Signature of authorized person or parent

 Date