

# Gallatin Women's Center

## Permission to release prescriptions to another individual

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give permission for the following people to pick up written prescriptions and/or sample medication and/or prescribed medication on my behalf.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Permission to release medical information to another individual

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please list the name (s) of any other individual (s) that you would allow to pick-up or receive medical information on your behalf, including, but not limited to, test results (lab and imaging), return to work/school letter, confirmation of pregnancy, and appointment reminders.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If you **do not** want any other individual (s) to receive your medical information, please initial here \_\_\_\_\_

In some instances we may need to leave you a message regarding your medical information such as appointment information or reminders, lab results, imaging results, or returned messages from a nurse. If you give permission to leave such information on your voicemail or answering machine, please list the numbers below

Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

\_\_\_\_\_ No, I do not wish for my information to be left on a voicemail/answering machine

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_