SHADID
MEDICAL GROUP

Authorization to Release Information via Phone/Family/Friends

Patient Name: _____ DOB: _____

If patient is a minor, parents do not need to add themselves to this list just other individuals.
I hereby authorize confidential communications from the physicians or staff of TPG regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ Work Phone: _____ Cell phone: _____

Email Address: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____
Patient Signature Date

TPG STAFF ONLY:

Documented by:

_____ _____
Initials Date