Due to HIPAA regulations we cannot release no any medical information or speak to anyone other than the patient regarding medical conditions or records unless we have written authorization signed by the patient. Please list the names of the individuals you wish to have access to your personal medical information and sign and date below.

Name	Phone #
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

X_____ _____
Patient Signature Date

We are prescribing non-narcotic medications using ePrescribe. Please give us your preferred pharmacy information. Please also include any mail-order prescription service that you use.

Pharmacy Information

_____	_____
Pharmacy	Phone

_____
Address

_____	_____
Pharmacy	Phone

_____
Address