

Hampden Medical Group Patient Contact Authorization Form

Print Patient Name

Date of Birth

Primary Phone number: _____

Hampden Medical Group **MAY / MAY NOT** leave messages related to my health information
(circle one)

Secondary Phone number: _____

Hampden Medical Group **MAY / MAY NOT** leave messages related to my health information
(circle one)

Hampden Medical Group **MAY / MAY NOT** discuss **MY / MY DEPENDENT'S** health information with:
(circle one) *(circle one)*

Name of Individual

Relationship to patient

Name of Individual

Relationship to patient

Name of Individual

Relationship to patient

The following person(s) is/are authorized to pick up written Prescriptions, correspondence, or Medication samples on my behalf:

Name of Individual

Relationship to patient

Name of Individual

Relationship to patient

Name of Individual

Relationship to patient

Patient / Guardian Signature

Today's Date

Printed Name of Guardian

Relationship to Patient

This Authorization Expires after _____
(length of time, or event)