Noel R. Williams, M.D.
Benjamin J. Barenberg, M.D.
Cassie Smith, M.D.
Abbey Krahl, PA-C
Amy Brooks, APRN
Bethany Cook, APRN
Christina Telcocci, PA-C
Shannan Carmouche, PA-C
Tricia Hall, PA-C

Authorization to Release Information via Phone/Family/Friends

Print your name: ____ DOB: ______________________

I hereby authorize confidential communications from the physicians or staff of this office regarding my healthcare, lab work, test results, treatments, appointments, prescriptions, etc… to be received at any of the phone numbers listed below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

DO not fill in numbers at which you do NOT wish to be contacted

Home Phone: _______________________ Cell: ________________________ Other:______________________

I authorize the following individuals **(spouse, family member, and/or friend)** to call the office on my behalf to verify the status of appointments, treatment plan, medications, and/or account information. These individuals may also pick up prescriptions and/or samples that I have requested. **(Leave blank if you do not authorize any other individual to access your protected health information)**

Name: ____ Relation: ____________________________

Name: ____ Relation: ____________________________

Name: ____ Relation: ____________________________

Name: ____ Relation: ____________________________

Below is the pharmacy name and phone number that I will use for all prescriptions

Pharmacy Name: _______________________________________ Pharmacy Number: ________________________

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

____ ___________________________________

Patient Signature Date