Authorization to Release Protected Health Information

Patient Information

Name:				
	First	Middle		Last
Address:				
	Street	City	State	Zip

Social Security #:		**DOB:**	
Home Phone:		**Cell Phone:**	
E-mail			

Authorization of Health Information Communication Methods

Indicate below the people with whom we may discuss your treatment and other health information.

Name	Relation to Patient	Phone Number	Member Initials

Authorization of Health Information Communication

Indicate below the methods in which Southern Scripts may communicate your health information.

Method	Is This Method Acceptable?		Member Initials
Home voicemail system	☐ Yes	☐No	
Cell phone voicemail system	☐ Yes	☐No	
E-mail Address	☐ Yes	☐No	
Text message to cell phone	☐ Yes	☐No	

Additional Comments:

Patient Signature:	
Date of Signature:	
Witness Signature	
Date of Signature:	

Please return this form to support@southernscripts.net or you may fax it to 318-214-4190.