



CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION AND SUPPLIES

Patient's name: \_\_\_\_\_ Acct# \_\_\_\_\_

I, \_\_\_\_\_ authorize Orangeburg Medical Group to also use or disclose my health information as indicated in my responses below.

My medical condition and information may be discussed with the following person(s). These individuals my pick-up medical supplies and/or information in my absence.

Do not list a physician on this form.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please circle your response:

- 1) Leave a message on my phone voice mail or answering machine? YES or NO
- 2) Leave a message with a person who answers my home phone? YES or NO
- 3) Contact me at work and tell them who is calling if asked? YES or NO
- 4) Leave a message on work phone voice mail or answering machine? YES or NO

\_\_\_\_\_

\_\_\_\_\_

Signature of patient (or patient's representative)

Date

\_\_\_\_\_  
Printed legal name of patient (or patient's representative)