PATIENT INFORMATION RELEASE FORM

DATE

NAME _____

DOB _____

I hereby authorize Cardinal Healthcare to contact and communicate by means of:

- ☐ Only Speak with Patient
- ☐ Only Speak with Designated Contact Person
  - Contact _____
  - Contact _____

- ☐ Approved to Leave Phone Messages
- ☐ Approved to Contact via Email

- ☐ Do NOT Leave Phone Messages
- ☐ Do NOT Contact at Work
- ☐ Do NOT Leave Medical Information on Phone Messages
- ☐ Do NOT Contact at Home

I hereby authorize Cardinal Healthcare to share my personal health information with:

- ☐ NO ONE other than myself and those required by law
- ☐ My Spouse
  - Name _____
- ☐ My Parents
  - Name _____
  - Name _____
- ☐ My Children
  - Name _____
  - Name _____
  - Name _____
  - Name _____
- ☐ My Friend
  - Name _____
- ☐ Other
  - Name _____

Patient/Legal Guardian Signature _____

Date _____