



RELEASE OF PHARMACEUTICAL INFORMATION

The undersigned does hereby authorize Scott and White Prescription Services to release certain information (to wit: _____)

From its records regarding _____
(Patient's Name)

to: _____
(Receiving Party's Name)

for the purpose of: _____

Date: _____ Name: _____

Relationship to Patient: _____ Self: _____ Other: _____

Released Period: From: _____ To: _____

RECEIPT

The undersigned acknowledges receipt of certain information from Scott and White Prescription Services pursuant to the above-Release. I acknowledge that the information is confidential and may be released by me only for the authorized purposes set forth above.

Date: _____ Name: _____

If Applicable, Agent for: _____ Address: _____

City, State, Zip: _____

Patient Signature: _____ Date of Birth: _____

Send completed form to:
Tammi Mitchum
4236 Lowes Drive
Temple TX 76502

OR

Fax completed form:
Attn: Tammi at 254-298-6189.