Louis F. Clarizio, DDS PA

**CONSENT FORM**

Disclosures to Friends/Family Members

Prescription Order Pick-up

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclosures to Friends/Family Members**

I consent to Dr. Clarizio and members of his staff acting on his behalf to disclose my Protected Health Information (PHI) for purposes of communicating results, findings, and care decisions to the following friends and/or family members:

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Contact Information |
|  |  |  |
|  |  |  |

**Prescription Order Pick-up**

There may be times when you need a friend or family member to pick-up a prescription order (script) from our office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present a valid photo ID and sign for the prescription.

\_\_\_\_\_\_\_\_\_\_ (patient initials) I wish to designate the following family member/friend to pick-up an order on my behalf.

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Contact Information |
|  |  |  |
|  |  |  |

\_\_\_\_\_\_\_\_\_\_ (patient initials) I do not want to designate anyone to pick-up an order on my behalf.

Please Note: Consent may to revoked at any point by written communication signed by the patient.