THE HAWKINS GROUP
PSYCHIATRIC CONSULTANTS

2431 East Glenn Ave, Suite 400, Auburn, AL 36830 | P: 334-275-7440| F: 334-218-5815

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, do hereby grant authorization to release information on my behalf regarding my treatment and condition to the following:

Name: _____ Spouse / Other

Phone: _____

May we leave a voicemail? ***Yes / No***

Name: _____ Parent/ Children/ Guardian

Phone: _____

May we leave a voicemail? ***Yes / No***

Please answer yes or no to the following questions about your contact information and appointment reminders:

- I have confirmed my email address and consent to receive appointment reminders, notices or other non-clinical information from The Hawkins Group staff or providers: **Yes / No**
- I consent to receive appointment reminders to my phone number via text message: **Yes / No**
- I consent to receive appointment reminder phone calls to my phone number: **Yes / No**
- I have confirmed my address and The Hawkins Group may mail information there: **Yes / No**
- My phone number is correct, and I consent to be contacted by The Hawkins Group for purposes related to treatment, payment, or other healthcare operations: **Yes / No**

It is my responsibility to make The Hawkins Group aware of any changes to this authorization. This authorization is in effect as long as I am a patient or until rescinded by me.

_____

Patient Signature Date