



Behavioral Health & Psychiatry, PA

Specialists in Evaluation, Treatment, and Consultation Since 1965

Appointment & Script Authorization

Patient's Name: _____

Patient's Date of Birth: _____

This authorization is for the limited purpose of obtaining from or releasing appointment information and scripts and/or samples to the following people:

This authorization will remain in effect unless you designate differently. You may revoke this authorization at any time by giving us **written** notice.

Patient's Signature: _____

Date: _____