



Behavioral Health & Psychiatry, PA

Specialists in Evaluation, Treatment, and Consultation Since 1965

Appointment & Script Authorization

Patient's name: _____

Patient's date of birth: _____

This form is for the limited purpose of authorizing the following people (*e.g. family members and friends*) to make, cancel, and/or verify appointments for me, and/or to pick up scripts or samples for me:

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: _____

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