

# Carolina Diabetic Supply Group, Inc.

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## Third Party Authorization Form

I, \_\_\_\_\_, hereby authorize the person(s) listed below to speak to the staff of CDSG, Inc. regarding my account. I authorize this individual to receive any account information and/or make any changes to my account including, but not limited to, placing an order for my diabetic supplies, inquiring about order history, inquiring about account balances and payments, inquiring about prescription statuses and/or details, and making changes to my account. This person is authorized to make any decisions regarding my account that would be required of me to make. I reserve the right to withdraw this authorization at any time.

*Authorized Third Party #1:*

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Phone #: \_\_\_\_\_

*Authorized Third Party #2:*

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Phone #: \_\_\_\_\_

*Authorized Third Party #3:*

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Phone #: \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

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Patient Signature

Date

Acct #:

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Carolina Diabetic Supply Group, Inc. PO Box 12734 New Bern, NC 28561  
Phone (800) 575-2291 Local (252) 633-2244 Fax (252) 633-4156

