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Patient Consent for Disclosure of Information

I authorize the release of my protected health information / financial responsibilities to the following person(s):

1. Name: _____

   Address: _____

   Phone: _____

   Relation to patient: _____

2. Name: _____

   Address: _____

   Phone: _____

   Relation to patient: _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

_____

{ } **I also authorize** my records to be released in the future with regards to my surgery
For example: FMLA, LEGAL OFFICES, Other Doctor's, etc….

{ } **I DO NOT AUTHORIZE** THE RELEASE OF MY INFORMATION TO ANYONE.

_____

Patient Signature Date

By signing this form, I authorize you to release confidential health information and/or financial obligations about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) listed above.