Physicians Alliance Surgery Center

An Affiliate of
Saint Francis Healthcare System

The Patient's Permission to Discuss Protected Health Information

I hereby request and give my permission that Physicians Alliance Surgery Center may discuss protected health information regarding my condition and care, for the current surgery / procedure of_____

_____with the following individuals **should they inquire.**

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Signature of Patient **Date**

If this patient currently has a Public Administrator, or any other legal representative for making healthcare decisions, please complete the following:

_____

Name Phone Number Type of Representative

Note: Please contact the above named individual for consents and authorizations and before releasing information to others