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:**

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Name Relationship

____

Name Relationship

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Name Relationship

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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