SOUTHERN
SURGICAL ASSOCIATES

Authorization for Use/Release of Health Information

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purposes.)

Name:_____

DOB: _____

Chart #:_____

From time to time, patient's family, friends or relatives call this office asking for appointment times, refill on medications, medical information regarding the diagnosis of the patient and to discuss or give results. Without written permission, we **cannot** talk to anyone other than the patient. If you want the staff to talk to anyone other than yourself about anything regarding your chart, please list the person(s) below.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

I understand that Southern Surgical Associates, PA assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Southern Surgical Associates, PA from all legal liability that may arise from this authorization.

Patient Signature:_____

Date:_____

Witness:_____