Surgical Arts PC

Patient Authorization to Release Patient Information

I hereby understand that I am authorizing Surgical Arts PC to provide my patient information to the names listed below:

1. _____ Relationship_____
2. _____ Relationship_____
3. _____ Relationship _____
4. _____ Relationship_____
5. _____ Relationship_____

I am also authorizing Surgical Arts PC to send and/or leave messages from Surgical Arts PC by ways listed below: (Please choose all ways in which you want to receive notification)

□ Voice Mail: □ Home Phone ( ) _____ □ Cell Phone ( ) _____

□ Text: Cell Number ( ) _____

□ Email: Email Address_____

□ Fax: Fax Number ( ) _____

Patient's Signature_____ Date_____

Print Patient Name _____Date of Birth_____