AUTHORIZATION TO RELEASE INFORMATION

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to individuals you must sign this form. Signing this form will only give consent to release this information to the following individuals indicated below. This consent form will not allow *CENTRAL ARKANSAS SURGICAL CENTER* to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow *CENTRAL ARKANSAS SURGICAL CENTER* to release my medical and/or billing information to the following individual(s):

1.________________________________ Ph: ______________________ Relationship ______________

2.________________________________ Ph: ______________________ Relationship ______________

3.________________________________ Ph: ______________________ Relationship ______________

Patient Name: ____

Patient Signature ____ Date: _____________________

Authorization to Leave messages with Household Members/Answering Machine

Occasionally it is necessary for the staff of *CENTRAL ARKANSAS SURGICAL CENTER* to leave messages for patients. The purpose of these messages is to obtain information regarding a scheduled procedure. At no time will a representative of *CENTRAL ARKANSAS SURGICAL CENTER* discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name ____

Patient Signature ____ Date ____________________