

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 **Cleburne Surgical Center** to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow **Cleburne Surgical Center** to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient _____

2. _____ Relation to Patient _____

3. _____ Relation to Patient _____

Patient Name _____

Patient Signature _____ Date _____

Authorization to Leave Messages with Household Members/Answering Machine

Occasionally it is necessary for the staff of **Cleburne 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 **Cleburne 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 _____