UNIVERSITY SURGICAL ASSOCIATES

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I (we), the undersigned patient and/or responsible party hereby authorize University Surgical Associates, PC, it's physicians, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc to the person or persons indicated below:

Spouse	Name
Parents	Name(s)
Children	Name(s)
Other	Name(s)

You **MAY / MAY NOT** (please circle one) leave information on my answering machine.

You **MAY / MAY NOT** (please circle one) release my records by fax machine.

You **MAY / MAY NOT** (please circle one) release my records by US Postal Service.

Patient Signature: _____ Date: _____