AVOYELLES SURGICAL ASSOCIATES

GENERAL SURGERY

RELEASE OF INFORMATION TO SPECIFIC FAMILY MEMBERS

DATE_____/_____/_____

PATIENTS NAME_____ DOB_____/_____/_____

ADDRESS _____

_____

I, _____, UNDERSTAND THAT THE INFORMATION CONTAINED IN MY MEDICAL RECORD IS CONFIDENTIAL. HOWEVER, I SPECIFICALLY GIVE MY CONSENT FOR: ***Avoyelles Surgical Associates*** TO RELEASE THE FOLLOWING INFORMATION TO ONLY THESE FAMILY MEMBERS OR DESIGNATED PERSONS REGARDING MY CASE AS LISTED BELOW:

_____

_____

_____

_____

INFORMATION WILL BE DISCLOSED ONLY TO THE ABOVE NAMES LISTED. THIS CONSENT IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME AT THE DISCRETION OF THE PATIENT

PATIENT SIGNATURE_____

(IF MINOR, SIGNATURE OF PARENT OR GUARDIAN)

_____

WITNESS

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WITNESS