Surgical Associates of Myrtle Beach

Authorization for Release of Information to Family and/or Friends

Patient: _____ Date: _____

Surgical Associates of Myrtle Beach is authorized to release protected health information about the above-named patient to the authorized people named below.

Print Name	Relationship/Phone#	Please circle the information each person may receive:
_____		**Clinical Appointment Financial**
_____		**Clinical Appointment Financial**
_____		**Clinical Appointment Financial**

If you have an answering machine or voicemail, may we leave a message regarding the following? Y N

Please circle each one signifying your consent **Clinical** **Appointment** **Financial**

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by contacting Surgical Associates of Myrtle Beach, and that I have the right to inspect or copy the protected health information to be disclosed as described in the document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in effect until revoked by the patient or the patient's representative.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Surgical Associates of Myrtle Beach Date