

SEVEN HILLS SURGICAL ASSOCIATES, P.C.

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PERMISSION TO DISCUSS PATIENT HEALTH INFORMATION

Patient Name: _____ DOB: _____

Account No.: _____

Please list below the names of any family members and/or friends that you will allow us to discuss your medical treatment with. You do not need to list any doctors. THIS FORM SUPERSEDES ANY PREVIOUS PERMISSION.

I hereby give my permission to the person(s) listed below to receive information about my care and treatment:

NAME	RELATIONSHIP	PHONE NO.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Patient, Parent or Guardian

Date