Saunders Oculoplastic Surgery, PSC

RELEASE OF INFORMATION AUTHORIZATION

If you choose to appoint an individual (family member/friend) to discuss your medical care, please complete this form. Under the requirement of HIPPA we are unable to release any information without patient consent.

I hereby give my permission for Saunders Oculoplastic Surgery, PSC to discuss my medical / billing information with the following:

_____	_____
Name	Relation to patient
_____	_____
Name	Relation to patient

I understand I have the right to revoke this authorization by written notification to Saunders Oculoplastic Surgery, PSC.

_____	_____	_____
Patient name (printed)	Patient Signature	Date