

Name: _____

DOB: _____

AUTHORIZATION FOR RELEASE OF SURGERY & TEST DATES AND TIMES

I hereby authorize **Shoulder & Elbow Center, PSC** to record and convey information regarding my appointment date and time and the surgery & test to be performed by designated means listed below. I understand that this **authorization** is voluntary.

Patient Name: _____ ID Number: _____

Patient's Address: _____

I hereby authorize **Shoulder & Elbow Center, PSC** to leave surgery & test dates and times at the following: **(please check all that apply)**

- Home Answering Machine _____ (number)
- Work Voice Mail _____ (number)
- E-mail _____ (e-mail address)
- Other _____

The patient or the patient's representative must read and initial the following statements:

1. I understand that my healthcare and the payment for my healthcare will not be affected if I do not sign this form. Initials: _____
1. The information to be released and the purpose for the release is to communicate to me the date and time of Surgery or medical testing and information regarding the surgery or testing to be performed. Initials: _____
2. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____
3. I understand that this **authorization** will expire on ___ / ___ / _____ or 12 months following date signed. Initials: _____
4. I understand that I may revoke this **authorization** at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions they took before they received the revocation. Initials: _____

Signature of Patient or Legal Guardian

Date

(Form **MUST** be completed before signing)

Printed name of Patient's Representative: _____

Relationship to the Patient: _____