MidAmerica
SURGERY CENTER

Consent for Release of Confidential Information to Relatives and Significant Others

I, _____, hereby give **MidAmerica Surgery Center** my consent to release confidential information regarding my health to the following individuals:

Please Print

Name	Relationship	Your Initials
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Name	Relationship	Your Initials
Name	Relationship	Your Initials

❒ I do not wish to have my information shared with anyone.

I understand that this consent is valid until it is revoked by me. I understand that I can revoke this consent at any time by giving written notice of my desire to do so. I also understand that I cannot retroactively revoke this consent in cases where the physician, or the staff acting on behalf of the physician, has already relied on it to disclose my health information.

Signature:	**Date**:

If the signature is not that of the patient, please specify the signer's relationship to the patient:

_____

Note: If the signer is the patient's Durable Power of Attorney (DPA), a copy of the legally executed document and valid photo identification is required to be on file with Precision Surgery Center. If the signer is the patient's spouse, valid photo identification is required to be on file. No one else is considered to be an acceptable signer.

Patient Label