General Surgical Associates

I, _____ give permission to Dr: _____
(Name of Patient)

to share my medical information with the following people:

1. _____ Relation to patient_____

2. _____ Relation to patient _____

3. _____ Relation to patient _____

This includes: scheduling/re-scheduling appointments for Clinical and Surgery.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date

In addition, I also give permission for any test results to be released to the person(s) listed above.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date