

I, \_\_\_\_\_, authorize any physician or staff member of Center of Surgical Specialists, PC to discuss my medical condition and treatment by telephone, fax or in writing to the following individuals. No information will be given to any person not listed below.

I understand that this form may be updated and/or revoked at any time by me in writing.

**Individual to give information to:**

**Relationship:**

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (Please print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_