AUTHORIZATION

All the personnel of Cane River Surgery Center take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

The authorization form, when completed and signed, allow our staff members to speak only with the individual or individuals you designate in the event that you are not able to receive our phone calls or you have an adult family member that helps coordinate your medical care. **YOU SHOULD NOT DESIGNATE A PHYSICIAN**.

If you feel, for example, comfortable allowing us to talk with another person regarding an appointment, then you should check that box. Please check all boxes that apply to your needs. If there is an additional person you wish to authorize, please complete the next section as you
did the first.

I authorize the employees of Cane River Surgery Center to speak with the following persons:

NAME:______________________________
NAME:______________________________

PHONE#:_______________ PHONE#:_______________

__________APPOINTMENTS __________APPOINTMENTS

__________ACCOUNTS/BILLS __________ACCOUNTS/BILLS

__________LAB RESULTS __________LAB RESULTS

__________TEST RESULTS __________TEST RESULTS

__________MEDICAL CARE __________MEDICAL CARE

I AUTHORIZE THE EMPLOYEES OF CANE RIVER SURGERY CENTER TO REVIEW
ALL MEDICATIONS AND MEDICATION HISTORY.______**YES** _____**NO**

INFORMATION REGARDING ANY OF THE ABOVE MAY ALSO BE LEFT ON MY
ANSWERING MACHINE OR VOICE MAIL._____**YES** _____**NO**

__________I DO NOT AUTHORIZE ANYONE TO RECEIVE INFORMATION

REGARDING MY MEDICAL CARE.

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Patient’s Signature or Legal Guardian   Date