KATY SURGERY, CENTER

24732 Kingsland Blvd.
Katy, Texas 77494
281-665-1050

Protected Health Information Release Form:

Patient Name: _____ Date: _____

(1) Concerning matters of my health, I give permission for Katy Surgery Center staff members to speak with:

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

_____

_____

Signature of patient: _____

Witness: _____