

Consent to Release Medical Information

I, _____ give authorization for the staff of Texas Laparoscopic Consultants, Dr. Yu and Dr. Scarborough to communicate medical information to the below listed family members and friends. These communications include, but are not limited to: information about the procedure I am having, the scheduling of pre-operative testing, the outcome of my surgery and condition, information regarding any complications, and my post-operative care. Information discussed could also include any additional health conditions (such as psychiatric problems, substance abuse and HIV status) I have, as related to my current condition and medical treatment.

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

_____ I DO NOT AUTHORIZE THE RELEASE OF ANY INFORMATION

Signature

Date

Print Name

Witness

Date