Augusta Surgical Group, P. C.

Patient Medical Approval HIPAA List

Date: _____

Patient Name: _____

Please list anyone below that we may discuss your medical information with. If their name is not on this list, we cannot disclose any of your medical information.

Emergency contact names for HIPAA list below

Name:_____ Relationship:_____Phone No: _____

Name: _____ Relationship: _____ Phone No:_____

Name: _____ Relationship: _____ Phone No: _____

Name:_____Relationship:_____Phone No:_____

Patient Signature: _____