



UNIVERSITY SURGICAL ASSOCIATES

Authorization to discuss or disclose Protected Health Information (PHI)

I hereby authorize University Surgical Associates office to speak to the following people regarding my medical condition:

NAME

RELATIONSHIP

_____	_____
_____	_____
_____	_____
_____	_____

I understand I may revoke this authorization at any time by informing the office in writing.

Patient Name (print)

Date of Birth

Patient Signature

Date

Guardian Signature/Relationship

Telephone



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A Clinical, Research and Teaching Affiliate
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