Advanced Surgical Associates
OF NORTHERN MINNESOTA

Authorization to Discuss Medical Information

Patient Name: _____ DOB: _____

I give Advanced Surgical Associates of Northern Minnesota permission to VERBALLY discuss my medical information with the following person(s):

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

I understand that my medical information may include information regarding communicable diseases (AIDS, HIV, etc.), alcohol/drug abuse or mental health treatment.

I must notify Advanced Surgical Associates of Northern Minnesota if changes are required, and new form must be filled out.

_____ _____
Signature Date

This is not an authorization to release medical information. Please complete Medical Record Release Authorization form if you'd like us to release your medical records.

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