MEMORIAL AND KATY SURGICAL SPECIALISTS

Authorization of Use and Disclosure of Protected Health Information

APPOINTMENT REMINDERS, TEST RESULTS, BILLING ISSUES, SURGERY SCHEDULING

This office may use your information to notify you of any changes in your scheduled appointment, to inform you of your test results, physician instructions, scheduled surgery instructions and/or billing issues.

Please indicate how you would like to be notified with the information.
(Check all that apply)

_____Home telephone#_____

_____Cell Phone #_____

If you have an answering machine/voice mail, may we leave detailed messages regarding appointments, treatment, information pertinent to your healthcare and/or payment for your healthcare provided by Memorial and Katy Surgical Specialists? _____YES _____NO

_____Work telephone #_____

_____Work voice mail May we leave detailed messages? _____YES _____NO

_____You may discuss any of my medical information with the following emergency contacts:

Name	Relationship	Telephone number
_____	_____	_____
_____	_____	_____

_____ _____
Patient Name (Please print) Date of birth

_____ _____
Patient/Guardian signature Date