Gulf Coast
SURGICAL CENTER, LLC

402 Dunn Street ● Houma, LA 70360 ● (985) 872-1661● Fax (985) 868-6938

COMMUNICATION AND AUTHORIZATION FORM

Patient Name: _____

Social Security Number: _____ DOB: _____

As a patient, you may want our staff to be able to communicate with certain individuals. In order to protect the privacy of your personal health information, please share with us the names of those individuals with whom we can discuss your care and share your protected health information.

Please list below those individuals whom will be at our facility with you on day of surgery:

Name:_____ Relationship to Pt.: _____

Name:_____ Relationship to Pt.: _____

Name:_____ Relationship to Pt.: _____

Please also list whom we can release your medical information to on your behalf. **If you would not like any information released to anyone other than yourself, please list no one.**

Name:_____ Relationship to Pt.: _____

Name:_____ Relationship to Pt.: _____

Name:_____ Relationship to Pt.: _____

Patient/Guardian Signature: _____ Date:_____