



PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I (we), the undersigned patient and/or responsible party hereby authorize Tuscaloosa Med Center South, PC, it's physicians, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc to the person or persons indicated below:

Spouse	Name
Parents	Name(s)
Children	Name(s)
Other	Name(s)

Patient Signature: _____ Date: _____