SURGICAL CLINIC ASSOCIATES, P.A.
501 Marshall Street, Suite 500
Jackson, Ms 39202

DUE TO HIPPA REGULATIONS WE ARE UNABLE TO DISCUSS YOUR MEDICAL OR FINANCIAL CARE WITH YOUR FAMILY MEMBERS OR FRIENDS WITHOUT YOUR WRITTEN PERMISSION. PLEASE DESIGNATE BELOW WHO YOU WANT US TO TALK WITH ON YOUR BEHALF.

THANK YOU.

I, ______________________________ give full authorization for the following
(YOUR NAME HERE)
person (s) to obtain any medical or billing information:

______________________________ RELATIONSHIP __________________

______________________________ RELATIONSHIP __________________

______________________________ RELATIONSHIP __________________

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(PRINT) Patient's Name

______________________________ __________________
(SIGN) Patient's Signature Date