LANCASTER SPECIALTY SURGERY CENTER

Patient Label:

Authorization to Discuss Protected Health Information

Print patient's legal name: _____

Previous names: _____ DOB: _____

1. **Phone Messages**
   My care team may leave information on my voice-mail or answering machine at these numbers:

   Home: _____ Cell: _____ Work:_____

2. **Person to person communication**
   While you are a patient at Lancaster Specialty Surgery Center (LSSC) as well as after discharge, who may we discuss your condition, post-operative status and discharge instructions/plan of care with?

   _____ _____ _____
   First name, Last name Relationship Phone

   _____ _____ _____
   First name, Last name Relationship Phone

3. **Billing**
   While you are a patient at LSSC as well as after discharge, is there a person(s), other than yourself, we may discuss billing information with?
   _____

I understand the following:

- This consent applies to Lancaster Specialty Surgery Center.
- This form does not expire. If I want to change the information on this form, I will fill out a new form.

Signature of patient or authorized person: _____ Date: _____