

**SENTARA SURGERY SPECIALISTS AUTHORIZATION TO
DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby authorize the following individuals to access my PHI.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please check if no authorization to disclose.

Patient's name (please print): _____

Signature: _____ Date: _____

Expiration Date: _____

If you are signing as a personal representative of the patient:

Name: _____ Relationship: _____

Signature: _____ Date: _____