SWAN SURGICAL
CARDIAC THORACIC VASCULAR

Release of Medical Appointment and Billing Information

By signing below, I authorize the physicians of Swan Surgical, and their staff to release information on file regarding my medical treatment and to leave information, when necessary, regarding appointment times and dates, with the person(s) listed below:

I understand that by signing this release, the designated person(s) listed below will be able to speak to any member of Swan Surgical. Furthermore, I understand that the physician's office cannot be held liable for any information the below stated person(s) may obtain regarding my medical care, my account, and/or appointment.

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

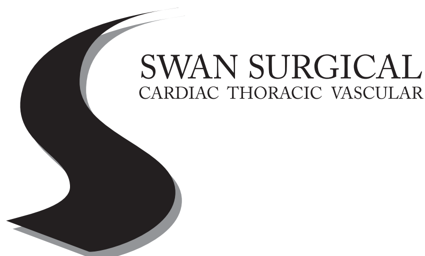
______________________ ______________________
Patient Signature **Date**

______________________ ______________________
Witness Signature (if Minor) Date

*****Sign below ONLY if you DO NOT AUTHORIZE INFORMATION RELEASE*****

I DO NOT AUTHORIZE anyone to have access to my appointment, billing, and/or medical information.

______________________ ______________________
Patient Signature Date



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