SOUTH PLAINS
SURGERY CENTER

Permission for Disclosure to Family, Friends, and/or Caregivers

To Patient:

I understand patient health information is protected and confidential. With this understanding, I hereby grant the **South Plains Surgery Center** staff permission to discuss my relevant health-related matters with family, friends, caregivers or other designated persons, listed below.

Name	Relationship
Name	Relationship
Name	Relationship

Transportation Contact Information

Name: _____

Relation: _____

Phone Number(s): _____

Address: _____

Patient Name: _____ Date: _____

Patient Signature: _____