Surgical Associates OF VENICE & ENGLEWOOD

Patient Name _____

In response to the Health Insurance Portability and Accountability Act, Surgical Associates of Venice & Englewood would like permission to disclose your confidential information and request that the following determinations are made which give us guidelines as to who you would like to have access to your confidential information.

Please place an X on the line(s) beside each name to advise as to what information we are permitted to share with each individual. If you list a name but no designation, we will assume that any/all types of information may be shared. We do NOT need the names of your physicians or Healthcare facilities, ONLY the names of your family and/or friends.

Name(s)	**Appointment**	**Financial**	**Medical**	**ALL**
_____	____	____	____	____
_____	____	____	____	____
_____	____	____	____	____
_____	____	____	____	____

I understand that the only way to change the permissions given above is to complete and sign a subsequent form. In addition, I agree that Surgical Associates of Venice & Englewood may leave appointment information on my home answering machine.

Patient Signature _____ Date _____

436 Nokomis Avenue South
Venice, FL 34285

5741 Bee Ridge Road
Suite 320
Sarasota, FL 34233