

**SURGICAL ASSOCIATES OF AUSTIN, P.A.  
1015 EAST 32<sup>nd</sup> STREET #308  
AUSTIN, TX 78705**

**I hereby authorize the release of my protected health information to the following individuals:**

\_\_\_\_\_  
**NAME**

\_\_\_\_\_  
**RELATIONSHIP**

\_\_\_\_\_  
**NAME**

\_\_\_\_\_  
**RELATIONSHIP**

\_\_\_\_\_  
**NAME**

\_\_\_\_\_  
**RELATIONSHIP**

\_\_\_\_\_  
**NAME**

\_\_\_\_\_  
**RELATIONSHIP**

\_\_\_\_\_  
**SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE**

**DATE**