Mission Surgery Center

Affiliated with Mission Hospital Regional Medical Center

PATIENT NAME ____

DATE OF SURGERY ____

Dear Patient or Patient's Authorization Representative:

Under the requirements of the Health Insurance Portability and Accountability Act we are required to treat your Protected Health information confidentially. It is necessary and important for both our business office and nursing personnel to contact you prior to surgery for the purpose of validating your insurance benefits and health information, and to provide you with pre-operative instructions prior to the day of your surgery.

Because we find that many of our patients have multiple phone numbers (work, home, cell) and because we are often greeted by answering machines, we require your authorization in order to leave this important information.

Please enter below those phone numbers we may call prior to and after your surgery at Mission Surgery Center.

Home: ____

Work: ____ **Ext.** ____________

Cell: ____

(1) May we leave a message or instructions on your answering machine?

☐ **YES** ☐ **NO**

(2) If you are not at home may we give instructions or information to a family member or friend?

☐ **YES** ☐ **NO**

Please PRINT Name and Relationship of Authorized Party/Parties:

____

____

MY SIGNATURE BELOW VALIDATES THE ABOVE-REFERENCED AUTHORIZATIONS.
A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

____ ____________ ____________

Signature of Patient/Patient's Authorized Representative **Date** **Time**