

Affiliated with Mission Hospital Regional Medical Center and the Sisters of St. Joseph of Orange

PATIENT NAME/DATE OF SURGERY		
Dear Patient or Patient's Authorization Representative:		
Under the requirements of the Health Insurance Portability and Acco to treat your Protected Health information confidentially. It is necessary business office and nursing personnel to contact you prior to surgery your insurance benefits and health information, and to provide you we prior to the day of your surgery.	ary and importan for the purpose	t for both our of validating
Because we find that many of our patients have multiple phone numbers are often greeted by answering machines, we require you this important information.	•	•
Please enter below those phone numbers we may call prior to and a Surgery Center.	fter your surgery	at Mission
Home:		
Work:	Ext	
Cell:		
(1) May we leave a message or instructions on your answering ma  ☐ YES ☐ NO		
(2) If you are not at home may we give instructions or information to ☐ YES ☐ NO	=	er or friend?
Please PRINT Name and Relationship of Authorized Party/Partie	es:	
MY SIGNATURE BELOW VALIDATES THE ABOVE-REFERENCES A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGIN		IONS.
Signature of Patient/Patient's Authorized Representative	Date	Time