Texas
Laparoscopic
Consultants

Consent to Release Medical Information

I, ______________________________ give authorization for the staff of Texas Laparoscopic Consultants, Dr. Yu and Dr. Scarborough to communicate medical information to the below listed family members and friends. These communications include, but are not limited to: information about the procedure I am having, the scheduling of pre-operative testing, the outcome of my surgery and condition, information regarding any complications, and my post-operative care. Information discussed could also include any additional health conditions (such as psychiatric problems, substance abuse and HIV status) I have, as related to my current condition and medical treatment.

______________________________ ______________
Name Relationship

______________________________ ______________
Name Relationship

______________________________ ______________
Name Relationship

______________________________ ______________
Name Relationship

______________________________ ______________
Name Relationship

__________ I DO NOT AUTHORIZE THE RELEASE OF ANY INFORMATION

______________________________ ______________
Signature Date

____
Print Name

______________________________ ______________
Witness Date