Advanced Specialty Anesthesia, LLC

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____

Patient/Parent/Guardian Name (print please)

give permission to the following medical doctors/specialists to release the requested protected health information to Advanced Specialty Anesthesia, LLC

In Regards To:

_____

Patient Name (print please) DOB

Primary Medical Doctor:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Other Medical Doctor/Specialist:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Other Medical Doctor/Specialist:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Submit to: **Advanced Specialty Anesthesia, LLC**
1201 Wakarusa Drive, Suite A-3
Lawrence, Kansas 66049
Phone: (785) 856-6170
Fax: (785) 856-6171

☑ **History and Physical**

☑ **Medication List**

☑ **Laboratory Results**

_____

Patient/Parent/Guardian Signature Date

_____

Primary Telephone # Cell # Work #