Mountain Home Surgery Center

360 Highway 5 N
Mountain Home, AR 72653

Fax: 580-0537 **870-425-2277** **800-451-3315**

Release Form

- **Permission to Speak to Individuals Involved in Patient's Care**
- **Including Financial Responsibility**

I, _____ , give **Mountain Home Surgery Center** permission to speak with the following people regarding my health status for health services I receive from **Mountain Home Surgery Center**, to include, but limited to: Diagnosis, Treatment Options, Financial Plans, Payments and Account Balances.

This consent is valid beginning today, until such time as I provide **Mountain Home Surgery Center** a written Revocation of Consent.

Mountain Home Surgery Center and their employees may speak with the following:

Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____

Signature of Patient Date