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:

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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) 422-5477

- [x] **History and Physical**
- [x] **Medication List**
- [x] **Laboratory Results**

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Patient/Parent/Guardian Signature Date

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Primary Telephone # Cell # Work #