Florida Oral & Facial Surgical Associates
Health Boulevard Surgical Center
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Drs. Richard T. Gaines, John O. Akers, & Curtis J. Schalit

PATIENT'S RIGHTS AND RESPONSIBILITIES

I have been given a copy of the Florida Patient's Rights and Responsibilities to review. I have been given the opportunity to discuss these Rights and Responsibilities and receive a copy if requested.

_____ _____
Signature of Patient/Legal Representative Date

AUTHORIZATION TO DISCUSS HEALTHCARE ISSUES

_____ _____
Name of Patient Date of Birth

I hereby authorize the above listed physicians and/or other staff members of Florida Oral & Facial Surgical Associates/Health Boulevard Surgical Center to discuss my healthcare issues with the following persons:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

I understand I have the right to:

- Receive a copy of this authorization
- Revoke this authorization

This authorization will remain in effect until the following date _____ or until otherwise notified (initial here): _____

_____ _____
Signature of Patient/Legal Representative Date

Relationship to Patient: (Circle One) Self Spouse Parent Other _____