

SOUTHEASTERN SURGICAL SPECIALISTS, P.C.
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AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician or other medical practitioner, hospital, clinic, other medical care institution, other companies or institutions to give Southeastern Surgical Specialists, P.C., or their reinsurers, information about me or my health for underwriting purposes. I further consent to the release of any drug or alcohol related information which may be protected by Federal Regulations.

(Signature of patient or guardian)

(Date)

(Date of Birth)

(Social Security Number)