Paragon Surgical Specialist
Medical Arts Center
200 Medical Park Drive, Suite 400
Concord, NC 28025
704-786-1108

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I _____, give permission for my medical
(Name of patient)

records and/or information to be given to _____.
(person to receive information and relationship to patient)

I understand I may revoke this authorization at any time in the form of written notice from me.

I HAVE READ, UNDERSTAND, AND AGREE TO THE CONTENTS OF THIS CONSENT.

Signature: _____

SS#: _____

Date: _____

Witnessed by: _____

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