CENTER FOR WEIGHT LOSS SURGERY

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Authorization for Release of Medical Record Information

and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug		e fill out this form and <u>send it to the</u> rm to our office.	provider's office	that is releasing	the information. Please DO NOT send	
Weight Loss Surgery (CWLS) at the address:/fax written above on this form. Name of provider or facility authorized to release information: Address: Phone: City: State: Zip: Fax: Fax: SPECIFIC INFORMATION TO BE RELEASED TO CWLS: Chart notes for one (1) visit per year for five (5) years. Please check with your insurance company if the weight history years need to be consecutive or not. Record of nutritional counseling Entire record Op-report(s) for the following abdominal surgery(fes): Stomach Adjustable Gastric Band Anti-Reflux (Nissen Fundoplication) Revision Gastric Bypass Duodenal Switch Other: EGD Cardiac Nuclear Medicine Scan Cardiac Stress Test Cardiac Catheterization Report(s) from abnormal finding from the following test(s): Pap Smear Other: Inderstand that authorizing the disclosure of the information identified above is necessary in order to receive treatment from the Center for Weight Loss Surgery. I further understand that the disclosure is voluntary and that 1 may revoke this authorization at any time by notifying the facility in writing. 1. I understand that authorizing the disclosure of ro which boxes are checked to be released diagnosis & treatment 1. Have carefully reviewed and considered	Patien	t Name:		Patient Date of Birth:		
Address:					rom my health records to the Center for	
City:	Name	of provider or facility authorized to rele	ease information: _			
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	Patient	Signature:			Date:	
	Legal Representative Signature:			Relationship:		
* If signed by Patient Guardian or Authorized Representative, documents must be provided to prove authority to sign on behalf of the patient.	-				-	

The facility or provider releasing the information may require a fee.