CENTER FOR WEIGHT LOSS SURGERY
34509 9th Avenue S, Suite 103, Federal Way, WA 98003 • 12303 NE 130th Lane, Suite 120, Kirkland, WA 98034
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Authorization for Release of Medical Record Information

Please fill out this form and send it to the provider's office that is releasing the information. Please DO NOT send this form to our office.

Patient Name: _____ **Patient Date of Birth:** _____

I hereby authorize the following named medical practice to release information from my health records to the **Center for 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: _____

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(ies):

- ❑ Stomach
- ❑ Anti-Reflux (Nissen Fundoplication)
- ❑ Gastric Bypass
- ❑ Adjustable Gastric Band
- ❑ Revision
- ❑ Duodenal Switch
- ❑ Other: _____

Report(s) from the following study(ies):

- ❑ EGD
- ❑ Cardiac Stress Test
- ❑ Cardiac Nuclear Medicine Scan
- ❑ Cardiac Catheterization

*Report(s) from **abnormal** finding from the following test(s):*

- ❑ Mammogram
- ❑ Breast Biopsy
- ❑ Pap Smear
- ❑ Other: _____

1. I understand 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 I have carefully reviewed and considered this Authorization before signing it. I further understand that I may revoke this authorization at any time by notifying the facility in writing.
2. I understand that my specific consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. I authorize the following records for which boxes are checked to be released. Checking the boxes is not a representation that such information exists.

   - ❑ Drug/alcohol abuse, diagnosis & treatment
   - ❑ HIV/AIDS testing, diagnosis & treatment
   - ❑ Sexually transmitted disease diagnosis & treatment
   - ❑ Mental health records

3. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient, but that re-disclosure is strictly limited by law.
4. This Authorization will expire on _____ (date).
   Unless otherwise specified, this authorization will expire 90 days after the date of this request.

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.