TLC | Surgery

PATIENT AUTHORIZATION
RELEASE OF PROTECTED HEALTH INFORMATION

RELEASE OF PROTECTED HEALTH INFORMATION

I authorize TLC Surgery to release copies of my protected health information.

Date of Request: _____

Patient Name: _____ Date of Birth: _____

PLEASE RELEASE TO:

Name of Person or Facility: _____

Address: _____

Phone: _____ Fax: _____

RECORDS TO RELEASE:

- ☐ History and Physical
- ☐ Lab Results
- ☐ Recent EKG
- ☐ Operative Report(s)
- ☐ Psychotherapy Notes
- ☐ Consultation
- ☐ Psychiatric
- ☐ Progress Notes:
  - *Height*
  - *Weight*
  - *Co-Morbidities*
- ☐ Nutrition Consultation
- ☐ Letter of Necessity from Primary Care Physician
- ☐ Other: _____

This information is being requested for approval of bariatric surgery.

I understand that if the recipient authorized to receive the information is not a covered entity, for example, insurance company or non health care provider, the release of information may no longer be protected by federal and state privacy regulations. I also understand that I may revoke this consent at any time in writing by completing the revocation authorization form, except to the extent that the action has been taking in reliance on it and that in any event this consent expires 1 year from when it is signed unless otherwise specified. (Otherwise specified date:) I understand that the provision of my healthcare and the payment for my healthcare will not be affected if I do not sign this form.

To the party receiving the information, this information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

Patient Signature: _____ Date: _____