



All portions of this form **must** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name _____ Date of Birth _____ Medical Record Number _____

Address _____ City _____ State _____ Zip _____ Telephone Number _____ Email Address _____

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information **The Center for Surgical Weight Loss**

131 Medical Park Rd., Ste 303

Agency or Individual(s) Authorized to Receive my Health Information **Mooresville, NC 28117-8525**

Mooresville, NC 28117-8525

Address _____ Telephone Number _____ Zip _____

(P) 704-660-4584 (F) 704-696-2929

- Health Information that may be used / disclosed is limited to the following:
- Discharge Summary
 - History & Physical
 - Consultation(s)
 - Lab
 - Pathology Report
 - Operative Note(s)
 - Imaging/X-Ray
 - X-Ray Reports
 - Entire Record
 - Other (specify) _____

Health Information that may be used / disclosed is limited to the following periods of healthcare:
 From (date): _____ To (date): _____ Account Number: _____
 From (date): _____ To (date): _____ Account Number: _____

- Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
- Treatment/Consultation
 - At Request of Patient
 - Research
 - Marketing
 - Billing or Claims Payment
 - At Request of Employer
 - Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Yes No If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature*		Date	Time
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, if Utilized	
Witness's Signature	Date	Time	Expiration Date or Event

- *Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.
- Electronic copy requested.

Authorization to Use and Disclose Protected Health Information

Patient Label