SURGICAL GROUP OF THE WOODLANDS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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Patient Name ______________________ Date Of Birth ______________________
Phone Number ______________________ Last 4 Of SSN ______________________

Above listed patient authorizes Surgical Group of the Woodlands to make records disclosure to and receive records from the following healthcare providers or facilities:

PLEASE LIST ANY DOCTORS YOU'VE SEEN IN THE LAST 5 YEARS:

Physician Name (First & Last)/ Specialty	Phone Number	Fax Number

DATES AND TYPE OF INFORMATION TO DISCLOSE:

- Please send 1 visit note with the patient's **HEIGHT** and **WEIGHT** from **each year that the patient was seen in your office**, or **for the past 5 years**
- Entire medical record for the past 2 years
- Entire medical record for the past 5 years
- Specific Information Requested:______________________

THE PURPOSE OF DISCLOSURE:

- Medical Care
- Consideration For Bariatric Surgery

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_______ I authorize this information to be disclosed to/from Surgical Group of The Woodlands

_______ I do not authorize this information to be disclosed to/from Surgical Group of The Woodlands

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
This authorization will expire on the date:___________. If no expiration date is specified, this authorization will expire 1 year from the date signed.

____
Signature of Patient/Parent/Guardian or Authorized Representative — Date

____
Printed Name of Authorized Representative — Relationship to Patient