



PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize New Life Center for Bariatric Surgery, a division of Premier Surgical Associates to disclose the health information described below for _____ (patient name). I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that I can request a copy of this form after I sign it.

Misys ID Number: _____

Purpose of Disclosure (check all that apply):

- Disability Insurance
- Life Insurance
- Workers Compensation
- Family Medical Leave Act (FMLA)
- Return to Work Release
- Other (please explain or write "at my request", if applicable): _____

Please provide the name and address of the company or person(s) receiving the records:

Name: _____
Company: _____
Street: _____
Street: _____
City, State & Zip _____

I request that the following information be released:

- My entire medical record including all surgeries and dates of service; or
- Just medical records for services between these dates ___/___/___ and ___/___/___;
- Other (please describe): _____

Expiration:

This authorization will expire on (choose one):

- (a) today, as signed and dated below
- (b) the occurrence of the following event related to the purpose of this authorization: _____

I understand that Premier Surgical Associates will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing this authorization.

I understand that this form authorizes a one-time release of information and cannot be used for future requests. I understand that each new request will require that I sign another authorization. I understand that I may revoke this authorization at any time by notifying Premier Surgical Associates in writing. The revocation will only be effective from the date it is received in this office and will not apply to the extent this authorization has already been relied upon.

Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____
Relationship to the patient: _____

Note: When this form is used, it is **NOT** necessary to record the disclosure on the non-TPO disclosure log. This form should **NEVER** be used for purposes of authorizing disclosures related to research or marketing.