AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____

Date of Birth: _____ Social Security # _____ (optional)

I authorize the following individual or organization to disclose the above named individual's health information:

Dr. _____ Phone: _____

For the purpose of: _____ Fax:_____

Please release the following:

_____ Entire Record

Or: ___ Progress notes for past year

___ Progress Notes
___ History/Physical Exam
___ Medication List
___ Weight Loss Program Records
___ List of Allergies
___ Other (Specify) _____

___ 2 year weight history/one progress notes for each year Weight for 2013 and 2014

___ X-Ray Films
___ Laboratory Results
___ EKG Reports
___ Cardiac Testing Information
___ Other Diagnostic Reports

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

___ **Yes,** I consent to the release of this information. ___ **No,** I do not consent.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
I understand that I have a right to 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 individual or organization releasing information. 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. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Ricardo Carrera, Office and Privacy Officer.

_____ _____

Signature of Patient or Legal Representative Date