

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name		Date of Birth	
Social Security #		Maiden/Other Name	
Patient Address			
Phone Number		Other Phone #	

I authorize _____ to release information contained in my medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services)

Name to who information may be released: Great Lakes Weight Loss/Michigan Obesity Surgical Specialists, the office of Dr. John Webber, Dr. Scott Laker and Dr. Matthew Weiner located at 4160 John R, Suite 615, Detroit, MI 48201. Please fax records to (313) 557-5234.

Phone: (313) 745-8476	Fax: (313) 557-5234
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	Discharge Summary	<input checked="" type="checkbox"/>	X-Ray Report		
<input checked="" type="checkbox"/>	History & Physical		X-Ray Films	<input checked="" type="checkbox"/>	Other: Weight Loss History for 2 years
<input checked="" type="checkbox"/>	Consultations		Operative Report		
<input checked="" type="checkbox"/>	Laboratory Results		Pathology Report		
					Dates of Treatment: Last 2 years

The purpose and need for such disclosure: Work-up for bariatric surgery.

For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.

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 health Information Management Department. We may have already released information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

Signature of Patient/Parent/Personal Representative

Date

If you are signing as a parent, guardian, or personal representative of the patient, describe this relationship and the source of your authority to sign this form below>

Relationship to patient

Print Name

Source of Authority: _____