ANCHORAGE BARIATRICS
For A New Beginning

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

_____ Appointment Date/Times _____ Diagnosis _____ X-Ray Results ____ Medications

_____ Lab Tests/Results _____ Summary of Medical Record _____ Care Plan

_____ Other (specify):
_____

_____

Patient Name_____ Date of Birth _____

Information to be given to:

Name_____

Relationship_____

Address_____

Phone_____

This authorization shall remain in effect from the date signed below until (please check one):

_____(Specify expiration date or event)

___ NO EXPIRATION DATE

I understand that:,.
-I may inspect or copy the protected health information to be used or disclosed
-I may revoke this authorization in writing by contacting your office, attention administrator
-This authorization is giving Anchorage Bariatrics the right to discuss my medical information with one or more people listed above.
-Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA
-I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment)

Signature: _____ Date:_____

Relationship to patient _____ (If signed by personal representative of Patient)