Bariatric Institute

Patient Authorization to Obtain Medical Information

This form allows Bariatric Institute, APC, to obtain medical records on your behalf.

Bariatric Institute, APC
Medical Records Department
790 E. Willow Street, Suite 100
Long Beach, CA 90806
Phone: 888-927-3220
Fax: 949-276-9631
Email: Info@BariatricInstitute.com

Patient Name: _____

Date of Birth: _____ Last four digits of SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

I hereby authorize my medical records, including, but not limited to, any and all medical records containing protected health information ("PHI") as listed below, to be released to Bariatric Institute, APC, its affiliates, medical staff, employees, counsel, and/or their designated representatives from the following:

Select the Delivery Method: ____ Mail ____ Fax ____ Email

Name of hospital/imaging facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

____ All medical records (reports, images, notes, labs) ____ Disc of all medical imaging

____ Specific Item (please list): _____

Please fax or email the above requested protected health information to the Medical Records Department at Bariatric Institute, APC at the above fax or email address.

The information above may be used and/or disclosed at my request.

This Patient Authorization to Obtain Medical Information ("Release") is effective one (1) year from the date signed below, unless and until revocation or modification is requested in writing by the patient, legal guardian, power of attorney, or health care surrogate, accompanied by the applicable documentation. I understand that I have the right to revoke or modify this Release at any time, for any reason or no reason at all. I also understand and agree that if I revoke or modify this Release, I must do so in writing and present my written request to Bariatric Institute, APC. Additionally, I acknowledge that it is my responsibility to confirm receipt by Bariatric Institute, APC, of such revocation or modification to this Release; such confirmation is required via certified mail. I understand and agree that the revocation or modification of this Release will not apply to information previously released in response to this Release. I understand and agree that once the protected health information or any other information is disclosed, it may be redisclosed by the recipient, and the information may not be protected under federal privacy laws or regulations.

I understand Bariatric Institute, APC will not condition treatment or payment based on or revocation of this Release unless otherwise allowed by law. A copy of this Release may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this Release.

Signature: _____ Date: _____
Patient/Guardian/Power of Attorney/Health Care Surrogate

Patient's Name: _____ Relationship to Patient: _____