Bariatric Institute

Patient Authorization to Release Medical Information

This form allows Bariatric Institute, APC, to release your medical records.

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 Bariatric Institute, APC, its affiliates, medical staff, employees, counsel, and/or their designated representatives to release my protected medical information, including, but not limited to any and all medical records containing protected health information ("PHI") in the method listed below, and to the following:

Select the Delivery Method: ____ Mail ____ Fax ____ Email

Requested Medical Records:

____ All Medical Records (reports, imaging, notes, labs)

____ Disc of all Medical Imaging

____ Specific Item (please list): _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

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

This Patient Authorization to Release Medical Information ("Release") is effective one (1) year from the date signed below, unless and until revocation or modification of this Release is requested in writing by the patient, legal guardian, power of attorney, or health care surrogate, accompanied by the applicable documentation. I fully 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 want to revoke or modify this Release, I must do so in writing and present my written request to Bariatric Institute, APC. Additionally, I acknowledge and agree 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 fully understand and agree that the revocation or modification of this Release will not apply to information previously released in response to this Release. I fully understand and agree that once the medical record, 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: _____