

**SURGICAL WEIGHT MANAGEMENT ASSOCIATES**

Eric Rau MD ▪ Fritz Rau MD ▪ David Rau MD ▪ Donald Schwab Jr MD

**AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)**

Patient Name		Request Date	
Address		Date of Birth	
City, State, Zip		SSN	
<b>I AUTHORIZE:</b> Surgical Weight Management Associates, LLC 5619 Hwy 311 Ste B Houma, LA 70360 Phone: 985-868-2206 Fax: 985-868-2232 <input type="radio"/> <b>TO RELEASE INFORMATION TO</b> or <input type="radio"/> <b>TO OBTAIN INFORMATION FROM</b> <b>(Check the box that indicates if the information is being released or requested)</b>			
Name			
Address		Phone	
City, State, Zip		Fax	
Purpose of this disclosure:	<input type="radio"/> Further Medical Care		<input type="radio"/> Personal
	<input type="radio"/> Legal		<input type="radio"/> Other _____
Authorization expiration date or event: (If not indicated, authorization will expire 12 months from date signed)			

Health information to be released under this authorization:			
Service Dates:	<input type="radio"/> Medical Notes/Summary	<input type="radio"/> History & Physical	<input type="radio"/> Pathology
<input type="radio"/> Operative/Procedure Reports	<input type="radio"/> X-Rays, EKG	<input type="radio"/> Recent Labs	<input type="radio"/> All Medical Records
<input type="radio"/> Other: <i>(please specify)</i>			

The following information will be released when included in the above <b>unless you indicate otherwise</b> . Do not release:	
<input type="radio"/> AIDS or HIV test results	<input type="radio"/> Mental health or psychiatric care
<input type="radio"/> Alcohol/substance abuse treatment	<input type="radio"/> Other: <i>(please specify)</i>

- I hereby authorize the use and disclosure of my individually identifiable health information as described above.
- I understand that if the person or entity receiving this information is not a health plan or health care provider covered by federal privacy regulation, the released information may not be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Surgical Weight Management Associates in writing. However, if I choose to do so, I understand that my revocation will not affect any information that was released prior to my revocation.
- I understand that this authorization is voluntary and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I have a right to receive a copy of this form after I sign it.

Signature of Patient:	Date:
Signature of Authorized Representative (if necessary):	
Authorized Representative's Relationship to Patient:	