AUTHORIZATION FORM TO SECURE AND RELEASE PROTECTED HEALTH INFORMATION (PHI)

I, ______________________________________ hereby authorize the Methodist Weight Loss Center permission to request or release information related to my care from the following providers:

Provider Full Name	**Phone**	**Fax**
Provider Full Name	**Phone**	**Fax**

Please check the following

___ Entire Record from ___________ to ____________

___ Laboratory Reports done on ____________________

___ History and Physical

___ Physician Orders

___ Physician Progress Notes

___ Emergency Room Reports

___ EKG from _____________

___ Ultrasound of _______________

___ CT of _____________________

___ Other ______________________

PLEASE SEND RECORDS TO:
METHODIST WEIGHT LOSS CENTER
8109 FREDERICKSBURG RD, SUITE 200
SAN ANTONIO, TX 78109
PHONE 210-575-8111 OR FAX TO 210-575-8697

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 organization releasing my information.
This authorization will expire in 180 days, unless a shorter time period is specified below.

This information will expire on the following _________________________.

PATIENT NAME _________________________________ DOB: ________________ SS# _______________

ADDRESS _____________________________ CITY _________________ STATE____________ ZIP ___________

____ ____________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**