ROLLER
WEIGHT LOSS &
ADVANCED SURGERY

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received Notice of privacy practices from Roller Weight Loss and Advanced Surgery_____(initial)

I hereby authorize the disclosure of my protected health information to the following non-healthcare related persons, or e-mail.

_____
Patients Name

E-mail:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time by notifying this physician's office in writing.

This authorization expires **one year from date signed below unless otherwise stated**.

_____ _____ _____
Signature of Patient or Guardian Date Expiration Date

_____ _____
Printed name of Patient Patients Date of Birth

Official General Surgeon
for the Arkansas Razorbacks®