



# Surgical Association of Mobile, P.A.

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## RECORDS RELEASE

Date: \_\_\_\_\_

To: \_\_\_\_\_

Address: \_\_\_\_\_

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORD (**OFFICE NOTES AND WEIGHTS**) IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT FOR THE LAST FIVE (5) YEARS. This information will be used to evaluate the patient for bariatric surgery and to obtain insurance precertification when necessary.

- TO:
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Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
(printed name)

Signed: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship: \_\_\_\_\_ Our chart # \_\_\_\_\_

Witness: \_\_\_\_\_ Expiration: \_\_\_\_\_

*The HIPAA Final Privacy Rule requires covered entities to safeguard certain Protected Health Information (PHI) related to a person's healthcare. Information being sent to you may include PHI after appropriate permission from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain PHI in a safe and secure manner. You may not re-disclose without additional patient consent or as required by law. Unauthorized re-disclosure or failure to safeguard PHI could subject you to penalties described in federal (HIPAA) and state law. If you the reader of this message are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, please notify us immediately and destroy the related message.*