AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Dr. Joshua Roller   Dr. Kristin Roller   Dr. Yong Kwon   Dr. Debbie Hays

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Patient's Name:

______________________________ ______________________________

Social Security # Date of Birth

I request and authorize: Name: ______________________ Fax# ______________

To release healthcare information of the patient named above to:

Roller Weight Loss & Advanced Surgery, 1280 E. Stearns, Ste. 5, Fayetteville, AR 72703, Fax: 479.445.6719

1501 S. Waldron Road, Suite 107, Fort Smith, AR 72903 Fax: 479.434.6354

This request and authorization applies to:

- O Healthcare information relating to the following treatment, condition or dates:

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- O All healthcare information
- O Other: ____

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Definition

I understand that my signature allows my medical information to be faxed or mailed to other physicians or insurance companies on behalf. A photocopy of this authorization shall be considered as valid as the original.

______________________________ ______________________________

PATIENT/PARENT/GUARDIAN SIGNATURE DATE SIGNED

THIS AUTHORIZATION EXPIRES 12 MONTHS FROM THE DAY IT IS SIGNED.

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Fayetteville, AR 72703
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Fort Smith, Arkansas 72903
Ph 479.434.6222 Fx 479.434.6354

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