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Tulsa, OK 74135
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www.rollerweightloss.com

# 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.

_____________________________________________
Patient's 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 redisclosed 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

______________________________________________ ______________________________
Printed name of Patient Patient's Date of Birth