



Bariatric Solutions

Authorization for Disclosure of Protected Health Information

(check one) Scott C. Stowers, DO Dirk I. Rodriguez, MD

I, _____, authorize the disclosure of my protected health information, as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

Name(s): _____

Telephone and Fax: _____

Address: _____

I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above.

Check one:

Scott C. Stowers, DO

Dirk I. Rodriguez, MD

800 Medical Center Drive Suite D
Decatur, TX 76234
Phone: 940-626-4683 Fax: 940-627-1654

6750 North MacArthur Blvd, Ste 211
Irving, Texas 75039-2875
Phone: 940-626-4683 Fax: 940-627-1654

Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

- | | | |
|--|--|---|
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Discharge Summary |

I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

Signature

Date

Name: _____ Address: _____

Telephone: _____ Social Security No.: _____

Relationship or Authority of Personal Representative (if applicable)