



PERMISSION TO GIVE/RELEASE MEDICAL INFORMATION

Patient Name _____ DOB _____

I, _____ give authorization for the staff of Bariatric Solutions and for the staff of (circle one) Scott Stowers, DO / Dirk Rodriguez, MD to communicate medical information to the family members and/or friends listed below. These communications include, but are not limited to: information about the procedures I am having, the scheduling of pre-operative testing, the outcomes of my surgery and condition, information regarding any complications and my post-operative care. Information discussed could also include any additional health conditions (such as psychiatric problems, substance abuse and HIV status) that I have, as related to my current condition and medical treatment.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Circle one Choice:

_____ I DO/ DO NOT AUTHORIZE THE RELEASE OF ANY INFORMATION
Initials

Signature _____ Date _____

Print Name _____

Witness _____ Date _____



Bariatric Solutions

Please contact me as follows (please check all that apply)

Home Telephone _____

- Leave message with appointment time and date
- Leave message with call back number only
- Leave message with family member
- Do not leave message

Cell Telephone _____

- Leave message with appointment time and date
- Leave message with call back number only
- Leave message with family member
- Do not leave message

Work Telephone _____

- Leave message with appointment time and date
- Leave message with call back number only
- Leave message with co-worker
- Do not leave message

I authorize the release of medical information to:

Name _____ Date of birth _____

I authorize the release of financial information to:

Name _____ Date of birth _____

I understand that I have the right to change this authorization at any time.

Patient or Guardian signature

Date