

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, authorize _____

to secure and/or release information for professional use, from the records of the patient listed below. I understand I may revoke this authorization at any time by notifying the authorized party with a dated, written revocation and my revocation has no effect on disclosures made prior to delivery. The professional person, social agency, institution, or organization receiving this information will be requested not to disclose this information without further written authorization by myself. The release authorization shall be terminated 90 days from the date of this signature.

Signature of patient or legal agent
(include relationship to patient)

Date

Signature of Witness

Records to be provided to: _____

Address: _____

Purpose or need for this disclosure: _____

Type of information to be disclosed: _____

PATIENT INFORMATION: Name: _____

Date of Birth: _____

Social Security #: _____

Approximate dates of treatment: _____

SSM DePaul Weight Loss Institute Fax: (314) 344-6801

