Texas Laparoscopic Consultants

Authorization for Release of Protected Health Information

I authorize: _____
(Name of Primary Care Physician/Specialist)

Phone: (_____)_____ Fax: (_____)_____

Please release my medical information to:
Texas Laparoscopic Consultants
ATTN: Sheilendra Mehta, MD
1200 Binz Street, Suit #950
Houston, Texas 77004

Phone: 713-493-7700
Fax: 281-971-4065

_____ _____
Patient Name Date of Birth

Please release the following information, indicated by an "X".

☐	History & Physical	☐	Psychotherapy Notes	☐	Nutrition Consultation
☐	Lab Results/X-rays	☐	Consultation	☐	Other
☐	Recent EKG	☐	Psychiatric		
☐	Operative Report(s)	☐	Progress Notes: -Height -Weight -Co-Morbidities		
☐	Letter of Medical Necessity from Primary Care Physician				

This information is being requested for approval of bariatric surgery.

I understand that if the recipient authorized to receive the information is not a covered entity, for example, insurance company or non health care provider, the release of information may no longer be protected by federal and state privacy regulations. I also understand that I may revoke this consent at any time in writing by completing the revocation authorization form, except to the extent that the action has been taking in reliance on it and that in any event this consent **expires 1 year** from when it is signed unless otherwise specified. (Otherwise specified date: _____) I understand that the provision of my healthcare and the payment for my healthcare will not be affected if I do not sign this form.

To the party receiving the information, this information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

_____ _____
Signature of Patient Date