



Standard Authorization of Use and Disclosure of Protected Health Information for Bariatric Surgery

To the patient: Please complete sections labeled "patient to complete" and return this form immediately to Central Carolina Surgery, P.A., 1002 North Church Street, Suite 302, Greensboro, NC 27401. Obtaining records can sometimes take an extended period of time. We ask for your assistance by completing and returning this form promptly.

Patient to complete (Please print)
Patient Name (print) SS# Phone# DOB
Street Address (print) City Zip
I do/do NOT authorize release of information related to AIDS or HIV Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.
Person/Organization to Whom Information May Be Disclosed
Information described below may be disclosed to:
Central Carolina Surgery, P.A.
Name of person/organization
1002 North Church Street, Suite 302 Greensboro NC 27401
Street Address City State Zip
Expiration Date of Authorization/Right to Terminate or Revoke Authorization/Potential for Re-disclosure
I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification to the Executive committee and Administrator of Central Carolina Surgery, but that it will not affect any information released prior to notification or cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or organization receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.
Patient's Signature Date
Patient Representative's Signature Relationship

To the primary physician: This patient has been accepted into the Central Carolina Surgery Bariatric Program and has an appointment in our office on . Please have the patient's records sent prior to this date.

For physician use only - ALL Records requested for past 5 years to include, but not limited to the following:
[] Discharge Summary
[] Pathology Report
[] Emergency Reports
[] History & Physical
[] Lab Reports
[] Office Notes
[] Radiology Reports
[] Operative Notes
[] ECG/EEG/Cardiac Cath