AUTHORIZATION FORM
RELEASE OF PROTECTED HEALTH INFORMATION

I, _____hereby authorize the following physician:

_____ at the following address

_____

to use and disclose to the following party:

CHRISTUS Southeast Texas Bariatric Center
3030 North Street, Suite 340, Beaumont, Texas 77702
Fax: (409) 839-5699, Phone: (409) 839-5673

The use and disclosure will be made by the office staff of this facility.

The health information to be used and/or disclosed is specifically described as follows
(check all information to be released):

_____Doctor's Office Notes and Reports
_____Lab/X-Rays
_____Communication Notes between Staff and Patient
_____Hospital Records
_____Psychiatric Notes
_____HIV/Drug Screen

Other Specific Testing: _____
_____

This authorization shall be in force and effective until the following event and/or date: _____ at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the aforementioned facility. I understand that a revocation is not retroactive to the extent that the facility has already used/disclosed information based on this current authorization. Also, a revocation is not effective if this authorization was a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The facility will not condition my treatment, payment, enrollment, in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure, I understand I have the right to:
1) Inspect or have a copy of the protected health information to be used or disclosed as permitted under federal law (or state law to the extent state law provides greater access rights),
2) Refuse to sign this authorization; in which case we will be unable to process this request.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Date of Birth Social Security #

_____
Name of Patient or Personal Representative